

# **Money Follows the Person Rebalancing Demonstration Grant**

## **Operational Protocol 2007–2011**



**State of North Carolina  
Department of Health and Human Services**

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**North Carolina Department of Health and Human Services**

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## Project Introduction

In May 2007, the Center for Medicare and Medicaid Services (CMS) awarded North Carolina a grant through Money Follows the Person Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. North Carolina intends to use the funds to develop a roadmap for rebalancing Medicaid long-term care delivery system. The goal is to move forward with a long term care system that provides an even greater array of home and community-based services and supports designed to promote choice and independence for individuals who are aging with care needs, or have physical, mental, or developmental disabilities. This goal will be carried out through the objectives noted below.

*Objective 1: Increase the use of home and community-based, rather than institutional, long-term care services.*

In 2004, the State Legislature passed House Bill 1414, section 10.12(a) mandating the Department of Health and Human Services, Division of Medial Assistance to develop a pilot program to implement the Program of All-Inclusive Care for the Elderly. This is a community based program that provides unique managed care benefits for the frail elderly. The program operates an adult day health center and:

- Provides a comprehensive array of medical and social services at the center
- Arranges for all in-home and referral services that may be required by each enrollee, and
- Uses an interdisciplinary team to manage care and services for each enrollee.

The first Program of All-Inclusive Care for the Elderly was opened in Wilmington, North Carolina in February 2008. Currently there are four enrolled participants with an anticipated enrollment of four participants per month. Two future sites are planned for Burlington (Piedmont) and Fayetteville. The Piedmont location has completed and submitted an application to CMS and is in the process of applying for Adult Day Health Care certification. The Fayetteville site has received approval from the programs' Board of Directors to pursue developing the program. Both future sites are expected to enroll an average of four participants per month.

*Objective 2: Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, which prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.*

Efforts are underway to build capacity for the delivery of Medicaid community-based services. Medicaid service definitions have been put in effect to support evidenced-based and emerging best practices. During this period of service transition, the Department of Mental Health, Development Disabilities and Substance Abuse Services has offered training and mechanisms to develop service capacity in the communities. A Governor's Executive Order, effective June 2006, implemented a revised service definition, improving quality and monitoring of care. North Carolina has developed a therapeutic care service definition that will be submitted to CMS for approval as a Medicaid-funded service, providing smaller community residences for children who need mental health treatment. Also, several new home and community, evidence-based treatment options were included in the new service package implemented in March 2006.

North Carolina's Division of Vocational Rehabilitation's Independent Living Rehabilitation Program receives recurring state funds to provide unduplicated, consumer-directed services needed to prevent nursing facility placements or to transition people from nursing facilities to the community. These services are administered by the Division of Vocational Rehabilitation in collaboration with the Division of Services for the Blind. The Division of Services for the Blind provides comprehensive, independent living services that help people who are blind or visually impaired meet their daily living needs in their homes/communities.

In 2006, North Carolina lifted the individual spending limit on services in the Community Alternatives Program for Mentally Retarded/Developmentally Disabled individuals (CAP/MR-DD) waiver program, providing opportunities for individuals with higher needs, such as those in state-operated developmental centers, to receive services in community settings; however, this has made it difficult to contain the costs for those individuals needing fewer services. In response, North Carolina has drafted a supports waiver that is limited to individuals who want consumer-directed options. This waiver, once implemented, will be utilized for those individuals with fewer support needs, freeing the comprehensive waiver for those with higher levels of need. The current, comprehensive CAP/MR-DD waiver has some limitations on individual services, and needs some additional services (such as intensive behavioral consultation and supports and crisis response services) to more adequately serve individuals with higher levels of need. Some individuals in the State developmental centers receive Social Security Disability Insurance rather than Supplemental Security Income, making it difficult for them to receive home and community based services in the community without a spend-down. While the spend-down provisions for Medicaid help individuals with higher incomes and substantial out-of-pocket expenses to become eligible for Medicaid, it has drawbacks for individuals needing long-term supports. While a person is meeting a deductible, Medicaid will not pay for services. Other options might offer a more stable platform for long term supports, while also offering a means to the State of collecting "excess income." The State continues to examine options that offer a stable platform for long term supports while offering a means of collecting "excess income." Under Medicare, some services (such as psychology) have different requirements for provider qualifications, often making those services more difficult to obtain.

The following issues restrict the flexible use of Medicaid funds to support individuals living in the community:

- Federal provisions reimburse Medicare Part D prescription drug co-pays for nursing facility residents, but not home and community based waiver participants whose income exceeds 135% of the federal poverty level and who have not met their Medicaid deductible
- Medically needy requirements that leave little money for persons to pay for living expenses in the community, while institutions provide room and board
- differences in spousal impoverishment rules can create hardships for families if a spouse prefers home or community-based services over institutional care
- application of the federal waiver cost neutrality requirement that results in caps in service below what is required to maintain someone in the community when applied on an individual basis

- enrollment caps for the waivers that limit number of people who can access care in the community
- no consistent differentiation of need among individuals on the CAP waiver waiting lists
- inconsistent access to waiver slots due to allocation of those slots to individual counties—thus, individuals in one county may have to wait for waiver services while other counties have unused waiver slots
- prior approval process delays appropriate care in the community
- the nature of the bundled funding for Intermediate Care Facility–Mental Retardation services and the fact that many of the facilities were built using Housing and Urban Development money and have six or more beds creates some cost-efficiencies.

*Objective 3: Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting.*

North Carolina has experienced success with transitioning individuals from nursing facilities. In September of 2002, CMS awarded North Carolina Division of Medical Assistance a three-year grant of \$600,000 to develop and conduct a **North Carolina Nursing Facility Transitions Program** in collaboration with North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program. In July of 2005, CMS approved a six-month no cost extension that extended grant-funded activities through March 29, 2006. As of March 2006, 134 individuals have been fully transitioned from nursing facilities to community living as a direct result of intervention managed, coordinated, and funded under this grant. The average length of time transitioned individuals remained in the community was 287 days at the time program evaluation data was reported.

The grant enabled North Carolina to demonstrate a successful collaboration between state agencies, regional non-profit organizations, and local agencies and groups. In particular, the North Carolina Division of Vocational Rehabilitation's Independent Living Rehabilitation Program and the Centers for Independent Living played key roles in identifying individuals for transition. Long-term care ombudsmen were also effective in identifying and referring nursing home residents interested in transitioning to community care. The agencies and organizations are committed to participating in these transition activities under the Money Follows the Person Demonstration.

North Carolina Nursing Facility Transitions Program Participant Task Force made recommendations—through lessons learned—to the Assistant Secretary of Office of Long Term Care at the conclusion of the grant project.

- Sustaining the transition process. Generally, it was recommended to make nursing facility transitions a priority via funding avenues which would produce supports needed to consumers for successful community living.
- Eliminate Intuition bias. This would involve education of stakeholders, increase education and outreach to hospitals, doctors, and the medical community about long term care community options, and implement Money Follows the Person grant. Additionally, it was recommended that the Governor of North Carolina reinstate the Protection Advocacy Agency as a private, non-profit entity, separate from the state government

structure. This occurred through the organization of Disability Rights NC, a private non-profit organization working to improve the lives of people with disabilities by protecting their rights.

- Improve affordable, accessible, integrated housing. The highlights of the recommendations were to support the CMS housing grant, seek ongoing funding for the Key Program, and increased publicity of the Low Income Housing Tax Credit and the State Housing Tax Credit.

*Objective 4: Ensure strategies and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based long term care services and to provide for continuous quality improvement in such services.*

Since Money Follows the Person will be implemented parallel with the 1915c waivers, the quality assurance protocols developed for each of the waivers will be the basis for the required quality assurance strategy. At this current time, renewals of waivers are being developed, along with stakeholder involvement, to be submitted by July 2008 (CAP/MR-DD) and October 2008 (CAP/DA). Standardizing quality measures across programs and populations is anticipated to strengthen service delivery and improve outcomes for consumers.

Through the above four objectives and benchmarks established specifically for North Carolina, the State will continue to increase and expand home and community-based service over institutionally-based services.

## Case Studies

The following case studies are intended to show how North Carolina's Money Follows the Person demonstration program will work from the consumer's point of view.

### Case Study for a Person with Developmental Disabilities

Caroline, who is 40 years old, loves people, big dogs, and the East Carolina University Pirates. Her affiliation with the Pirate Nation runs deep; she grew up in Greenville, where ECU is located. As a little girl, she attended the local school during the week, went to Pirates football games on Saturdays, and attended First Baptist church on Sundays. Caroline's family still lives in Greenville.

Although Caroline has cerebral palsy, uses a wheelchair, and requires total physical assistance, she had a fairly typical life experience until her mother died in 1980, when Caroline was 12. Her father, Frank, tried to piece together support for Caroline so he could continue work at a boat production factory, but he still had to miss work (and lose income) regularly when assistants weren't available.

In 1980, the only state-funded support option available to Caroline and her family was institutional care at the Caswell Developmental Center in Kinston, about one hour away from Greenville. As a result, Caroline's family doesn't get to visit her much. She has two younger brothers she was close to growing up, but she doesn't get to see them much anymore, and they miss her. Caroline has a baby niece she's never met, and she hasn't gone tailgating at a Pirates football game in over 27 years.

Like everyone, Caroline needs some support to think through major life decisions, but can largely make decisions on her own. Because she has spent most of her life in the developmental center, Caroline sometimes needs "community" concepts explained to her. She is her own guardian and the people who know her best don't think she needs anyone else in that role.

### Participant Identification

**Caroline learns about Money Follows the Person:** Sara, Caroline's case manager at the Caswell Developmental Center, and Sam, from the North Carolina Association of Self Advocates, had a joint conversation about Money Follows the Person with every person on Sara's caseload. Together, Sara and Sam told each person about this opportunity for people to receive supports in their hometowns, to reconnect with their families, to possibly get jobs, and to do the things they enjoyed (like going to Pirate football games!). Sara and Sam were sure to tell people that the transition wouldn't always be easy, and community-based supports would pose some new challenges, but that this project gave people in developmental centers more choices about where they lived.

Caroline was thrilled about the chance to go back home to Greenville and reconnect with her family and childhood friends. After Sara and Sam spent a couple of hours talking with Caroline about the Money Follows the Person project, they asked her if she wanted to participate. When Caroline eagerly said "yes," they assisted her in completing the *Community Options Interest*

*Survey* and then submitted it to the East Carolina Behavioral Health local management entity for consideration.

With Caroline's permission, Sara and Caroline called Caroline's father to share the news about the Money Follows the Person demonstration project and the possibility of Caroline moving back to Greenville. He had heard something on the radio about the state's effort to support people in moving home, but wanted more information on the specifics.

Caroline's father loved his daughter and trusted Sara and the other staff at the developmental center. After all, they had taken care of his daughter for almost 30 years. Yet, he was a little anxious about what it meant for Caroline to move back to Greenville. Would he be expected to make sure Caroline had the supports she needed by himself? He was 65 years old and was still working. Sara acknowledged his concern and noted that the community resources and supports available to Caroline in Greenville were significantly more available and stable than they had been in 1980. Sara and Caroline ended the conversation with Frank by reassuring him that his involvement in the process did not obligate him to anything and that he would be supporting his daughter's dream by participating in the planning process.

### **Prior to Transition**

The local management entity matched Caroline with a transition coordinator, Tammy, from the area. Tammy was deeply invested in the idea of people living in their home communities. Tammy viewed her role as Caroline's and her family's guide through the process and as a matchmaker to the community-based services available, including case management services. She also understood that her first commitment was to Caroline; and she would do everything she could to ensure Caroline's family received the information and support they needed to be supportive of Caroline's decision to transition back to Greenville.

While her role as Caroline's transition coordinator was temporary, Tammy understood how critically important it was. There are so many details and logistics associated with successfully transitioning people. Tammy also understood that a key part of her role was to build positive relationships with everyone involved. She understood that the success and stability of a person's community living experience largely rested on everyone's ability to work together and to trust each other. Tammy was well networked among the state's advocacy groups. These groups would be essential in assisting with the day-to-day logistics for transitioning Caroline and others out of the developmental centers. Though these groups would work in tandem with Tammy, Tammy was ultimately responsible for the transition's success.

In Caroline's case, Tammy would rely heavily on Allison, a family-advocate from Family Advocacy, Inc., in Greenville. Family Advocacy had significant experience in helping people with developmental disabilities transition out of developmental centers and back into local communities.

Tammy and Allison scheduled a Saturday visit at Caswell Developmental Center with Caroline and her family (father Frank and brother Bill—at Caroline's request) together. Tammy knew that she would not be directly participating in all of the logistics and meetings about Caroline's

transition. However, because she was ultimately responsible for the transition's success, she felt it was really important to attend every person's first meeting. After the first meeting, Allison would take the lead on the coordination and logistical details and would talk with Tammy regularly to keep her updated on the progress of Caroline's transition.

This first meeting was critical as it gave everyone involved an opportunity to talk about some of the basic living arrangements Caroline wanted in Greenville and some of the supports she would require. Tammy understood that the state's service delivery system was complex and often confusing to service users and their families. At this first meeting, they all talked informally about Caroline's coming back to Greenville, where she might enjoy living, the kinds of supports she would need, what activities she would enjoy, and the potential timeline for making the transition. While additional people (like provider agency staff) would need to be brought in to fine tune the details of Caroline's support structure, it was important for Tammy to have a broad understanding of Caroline's support interests and needs to ensure that the transition process honored her basic preferences.

**The First Meeting of Caroline's Crew:** At the end of the meeting, Tammy asked Caroline if she wanted to move forward with the process. Caroline eagerly said yes. With the others as witnesses, Tammy assisted Caroline in reviewing and signing the Informed Consent form. Tammy asked Caroline and others who else should be a part of the process. Caroline asked if Bill's wife, Wendy, could become part of her crew. Wendy had always talked "girl talk" with Caroline during their visits and Caroline trusted her. Bill agreed to ask Wendy to come to the next meeting.

At the end of the meeting, Tammy provided Caroline, Frank, and Bill with her contact information and with individual packets of information about the Money Follows the Person demonstration project. She also promised to send them a written summary of the meeting they just finished.

**Connecting Caroline with Service Coordination/Case Management Services:** After getting to know Caroline and her family a bit, Tammy and Allison knew their first priority was supporting Caroline through the process of selecting a long-term, community-based service coordination service. There were three qualified coordination services in the Greenville area.

While ideally, representatives of each agency and Caroline would visit individually, it sometimes was logistically difficult to make this happen. East Carolina Behavioral Health had recognized the logistical hurdle and organized a service coordination provider fair two times each month. This provided an opportunity for people coming into services for the first time, either through the Money Follows the Person demonstration project or other channels, to learn about the different service coordination agencies in order to make a more informed decision. Allison knew the dates of these fairs and worked with Sara to secure developmental center transportation to bring Caroline and a few others who were transitioning back to the East Carolina Behavioral Health region.

At the Service Coordination fair, Allison and Caroline listened to the presentations and asked questions that had emerged from their day-long conversation on Saturday. Tammy was careful

to ask questions she knew would be important to Caroline and Frank based on the comments from their meeting so that Caroline could make a fully informed decision.

After the fair, Allison, Caroline, and Donna (Caroline's direct support staff from the developmental center) talked over lunch about which agency Caroline preferred. Caroline really liked "Your Best Life" agency because the staff knew much about the housing market and how to help consumers get their own homes. Allison assisted Caroline in completing a freedom of choice form and then submitted it on Caroline's behalf. A few days later, a representative from Your Best Life called Tammy to confirm their services and to introduce Tammy to Caroline's new service coordinator, Chris, pending Caroline's final approval, of course.

By working through joint phone calls and e-mails, Allison, Chris, and Sara arranged the next group conversation about Caroline's supports. Allison, Chris, and Caroline's family would spend another Saturday on the road to visit Caroline and her staff at the developmental center.

This day-long Saturday conversation covered a lot:

- Caroline and her family got to know Chris, Caroline's service coordinator.
- Allison facilitated a personal futures planning session that gave Caroline the opportunity to think about what she wanted in her life and be more specific about what kind of supports she would need. This session wasn't really about services, specifically, but rather a chance for everyone to understand what Caroline hoped to get out of her life.
- Chris facilitated the group's development of a preliminary service plan based on Caroline's life goals and service support needs. Chris was responsible for making sure this plan of care met all of the relevant system requirements and for submitting the plan to East Carolina Behavioral Health. Chris provided information about the different providers that could meet Caroline's support needs.
- They discussed which providers Caroline would like to interview and she decided that she wanted Chris, Donna, Allison, Frank, and Wendy to be there to interview the providers as well if they could.
- Allison made sure Caroline received information on abuse/neglect policies, cost-sharing requirements, her other personal responsibilities, the state's complaint process, and other materials. Sara agreed to assist Caroline in processing the documentation more thoughtfully after the meeting.

While Chris was now involved and assisting in the transition process, everyone was clear that for as long as Caroline was in the developmental center, Allison remained the point person for the transition process, and Tammy continued to assume ultimate responsibility for the transition's success.

**Identifying a Provider:** Chris was able to assist Caroline in narrowing down the possible provider agencies to two that were able to meet her support interests and needs. Through joint conference calls and e-mails that Allison arranged, Chris organized an opportunity for Caroline, her family, and the others she had identified to meet with the two provider candidates.

Sara arranged transportation for Caroline and her staff to visit Greenville and meet with potential providers. Bill (Caroline's brother) was able to join Caroline, her staff, Tammy, and Chris in meeting with the two providers. Both providers were very aware of the Money Follows the Person demonstration project through provider networks and the state-published information they received in the mail and on the Web.. During the visit with each provider, Caroline and her crew got to talk to members of the provider's management team and direct support staff and were able to visit others served by the organization.

Caroline's crew and the two organizations discussed the kind of living options each could provide based on Caroline's preferences. One organization, Community Support Options ("Options"), indicated they fully supported Caroline to live in her own home and would help her secure community-based accessible housing—but to make the money work, she would likely need a live-in companion or a roommate.

After the full day, Caroline decided she really liked Options because of the level of flexibility they would provide her in creating her own supports. Tammy, Chris, and the provider staff all talked to Caroline and her family about how sometimes funding limits service options, but Caroline really liked that Options made a commitment to "figure out good solutions" and supported Caroline's dream of living in her own home.

## **Transition to Community Life**

**Making the Transition:** When Caroline selected Options, the organization's management team created budgets for several different support scenarios that would meet Caroline's needs and be financially viable. The Options manager, Marissa, met and became part of Caroline's crew, making several trips to visit Caroline at the center. Through these visits, Marissa was able to get to know Caroline and observe firsthand what kind of supports she needed and what worked for her. Marissa took extensive notes.

Through regular conference calls and face-to-face meetings, Caroline and her crew began to shape the structure of her supports in Greenville. Topics discussed included

- Caroline's living quarters (an apartment with modifications funded by the Money Follows the Person project);
- her proposed roommate (another Options client whom Caroline met and liked);
- her staffing pattern, based on her scheduling preferences and personal interests (24/7 support, with Bill and Wendy helping Caroline go to church on Sundays);
- her transportation (a wheelchair-accessible van); and
- her transition of her medical and financial services to Greenville

ECU's last home game was scheduled for the Saturday of Thanksgiving weekend. The apartment was ready. Caroline's staff was trained. And even though it was slightly ahead of schedule, Caroline's crew decided to do whatever it took to formalize the transition in time for the holiday and the last Pirates game of the season. The apartment manager agreed to prorate her living expenses for November. Caroline's family agreed that if Options could ensure that Caroline's overnight staff were available Thanksgiving night, Caroline would spend Thanksgiving with her family without paid support during the day.

On the Monday before Thanksgiving, Caroline's crew met one last time at the developmental center. The center had been her home for nearly 30 years and it was important to Caroline to stay in touch with some of the other residents and staff to whom she had been close. The center staff threw Caroline a party, and Tammy made sure that everyone had Caroline's new contact information and that Caroline had the contact information for those people she cared about.

Caroline's crew met for a final meeting with everyone: Sara, Donna, Allison, Tammy, Marissa, Caroline's family, and (of course) Caroline herself. They went through the final checklist that outlined the numerous details—both anticipated and unexpected—that had to be addressed before the transition could be complete. They tied up loose ends and officially transferred lead coordinator responsibilities from Tammy to Chris. Caroline's crew helped load up Caroline's things and, in an accessible van that Options had made available, brought Caroline home.

Caroline enjoyed her first home-cooked Thanksgiving meal in nearly 30 years and cheered her Pirates to victory in their final game of the season!

### **Fully Transitioned into a Home and Community-Based Program**

Thanks to the hard work and continued involvement of Caroline's crew, she is thriving in her new life. While there have been some bumps in the road (one of Caroline's staff accepted a new position three weeks after Caroline moved back to Greenville!), Options has remained responsive to meeting Caroline's needs. Marissa arranged coverage, with Caroline's remaining staff pitching in, until she could identify a new candidate. Caroline met and approved the candidate and now Candace is a valued part of Caroline's staff.

For two months after Caroline moved back, Tammy and Allison continued to check in with Caroline about how things were going. Tammy and Chris worked together to make sure all of the loose ends around the transition were tied up before Tammy turned over responsibility to Chris. Chris is now Caroline's point person and visits her at least once a month. Since her services are still new, Chris works hard to visit Caroline a few times a month until she is fully settled.

Caroline and her Greenville crew meet every few months to debrief on what's working and to work on how to address challenges that have emerged. Chris organizes these meetings around Caroline's volunteer job at the Humane Society.

Caroline's staff also attends professional development opportunities that focus on the emerging needs of people who have transitioned back into their communities. These trainings are funded by the Money Follows the Person demonstration project. Community-building remains a key topic. While Caroline's transition process revealed a rich network of natural supports, it was recognized that many people transitioning back into their communities would need staff assistance to develop and sustain unpaid relationships.

All in all, Caroline's transition process back to her hometown was a success and can serve as an example to others of what is possible under the Money Follows the Person demonstration project.

The Key Players:

Caroline: person using services

Caroline's Family:

1. Frank: Caroline's father
2. Bill: Caroline's brother
3. Wendy: Bill's wife

Transition Team:

1. Tammy: transition coordinator
2. Sara: developmental center staff member
3. Sam: joint surveyor/self-advocate
4. Donna: Caroline's key direct support staff person in the developmental center
5. Allison: staff member from the local advocacy group that is working with Tammy to coordinate Caroline's transition process
6. Chris: Caroline's new case manager/support broker in Greenville
7. Marissa: manager at Caroline's new support agency in Greenville

## **Case Study for an Individual with a Physical Disability**

### **Background**

Greg is 30 years old and had been living at the Shady Lawn Nursing Home since February 2007. In October 2006 Greg was involved in a car accident and sustained a C-6 level spinal cord injury. Prior to the car accident Greg was living with his wife and infant son in their home in Durham, North Carolina, and working as an electrical engineer for Duke Power. After the accident, Greg's wife was not able to provide the level of support that Greg needed to live in their home.

Greg was transferred to the Shady Lawn Nursing home in February of 2007 after he was discharged from an inpatient rehabilitation program. Greg continued to receive outpatient physical and occupational therapy while living at Shady Lawn, and Shady Lawn staff provided transportation to his appointments. Although Greg made a lot of progress in rehabilitation and regained much of his upper body strength, he had very limited use of his hands and was unable to transfer himself in and out of his wheelchair upon entering Shady Lawn. He also needed some level of assistance with most daily living skills.

### **Participant Identification**

In August 2007, Greg had been living at Shady Lawn for 6 months. Although his wife and son came by for visits at least three times a week, he missed seeing them on a daily basis and felt he was missing major milestones in his son's life. He also felt that he was too young to be living in a nursing facility and did not want his stay at Shady Lawn to be a long-term solution. While online researching alternatives to his present situation, Greg located the number for the Alliance of Disability Advocates Center for Independent Living (CIL), a local agency. He called the Centers for Independent Living and spoke with the transitions specialist on staff.

The Centers for Independent Living transition coordinator met with Greg at Shady Lawn, where he briefly assessed the supports that Greg currently had available to him and the supports that would need to be arranged in order for him to live with his family in the community. During their visit, the Centers for Independent Living transition coordinator told Greg about a new program called Money Follows the Person and explained how the program could help Greg transition to the community. He also gave Greg some printed information about the Money Follows the Person program. He told Greg to share the information with his family and to decide if he would be ready to develop a transition plan to move to the community.

A week later, Greg called the transition coordinator and stated that he and his wife were ready to begin discussing a transition plan. Greg and the transition coordinator arranged a meeting with Greg, his wife, the transition coordinator, the Money Follows the Person transition coordinator, and a social worker from Shady Lawn.

## **Prior to the transition**

At the meeting, the Money Follows the Person transition coordinator explained the Money Follows the Person program to Greg and his wife in more detail, including what service options could be available to Greg once he moves out of the nursing facility, such as CAP/DA or CAP/Choice. The group also completed a more thorough relocation assessment to determine all of the supports that would be needed in order for Greg to successfully transition to living in the community. The Shady Lawn social worker shared the Medicaid Uniform Screening Tool that had been completed when Greg first moved to Shady Lawn. The group used that assessment and additional information provided by Greg and his wife to gather the following information for Greg's transition plan:

- Personal data
- Professional care needs such as the continued need for physical and occupational therapies
- Health care needs
- Mental health/counseling needs
- Housing preferences and any needed home modifications
- Family supports
- Available social networks
- Transportation needs
- Public and private supports needed
- Assistive technology needs

Greg stated that he would like to move into the house that he and his wife own, but it would need to be modified to make it wheelchair accessible. Greg said he thought he would need personal attendant services 2 hours each morning and evening to assist him with bathing, dressing, and other personal care tasks. Since his wife currently works from home, she would be available to help him prepare meals during the day. The Money Follows the Person transition coordinator assisted Greg in setting up an appointment with a CAP case manager at the Department of Social Services in Durham County, who would help him determine the best service options for him.

The Centers for Independent Living transition coordinator gave Greg contact information for accessible public transportation in Durham County. Since Greg's family does not currently own a wheelchair-accessible vehicle, he would need to utilize public transportation to travel to his medical appointments. The Centers for Independent Living transition coordinator also put Greg in contact with another individual whom the Centers for Independent Living had previously helped to make a successful transition out of a nursing facility. That individual was able to let Greg know exactly what the transition process would be like and provide peer support. This began Greg's Circle of Friends.

## **Transition into community life**

Greg and a CAP case manager determined that CAP/DA would be the best option for Greg; however, there would be a two-month waiting period before a slot would become available. During that time, Greg and the two transition coordinators (Money Follows the Person and (Centers for Independent Living) worked to make his house ready for Greg to move in and to set up all of the necessary supports discussed in his transition plan. Greg was able to secure accessible transportation services through Durham Public Transportation. The transition coordinators utilized the Money Follows the Person one-time transition expenses to contract with a builder to construct a ramp leading to the front of Greg's house and to widen some of the doorways. With help from his family and friends, Greg was able to raise money to install a wheel-in shower in his downstairs bathroom. The Centers for Independent Living transition coordinator and Greg worked together to secure other needed equipment, such as a shower chair and hospital bed, utilizing Medicaid funding.

After two months Greg's CAP/DA services were in place, and his house modifications were completed. Greg, his wife, the Centers for Independent Living transition coordinator, and the nursing home social worker all worked together to ensure a seamless transition as outlined in Greg's transition plan.

CAP/DA services provided an in-home aide 4 hours a day for Greg. Greg also requested a personal emergency response system through CAP/DA so that he would be able to quickly call for help should an emergency arise when his wife was running errands during the day.

### **Fully Transitioned into a Home- and Community-Based Program**

The two transition coordinators met with Greg and a coordinator from the home health agency shortly after Greg's move to his house to ensure that the needed supports, including his attendant services, were in place. The Money Follows the Person transition coordinator regularly followed up with Greg by telephone for several months after Greg's transition to the community, and the Centers for Independent Living transition coordinator also remained in contact with Greg and his family. The transition coordinators and Greg held monthly face-to-face meetings, which helped them work together to address challenges that arose as Greg adjusted to living at home.

When Greg expressed a desire to start working part time hours, the Centers for Independent Living transition coordinator helped Greg contact Vocational Rehabilitation to begin receiving services from them and also put Greg in touch with the North Carolina Assistive Technology Center so that he could be assessed for voice input systems for his computer. Eventually Greg joined a support group of others in his area who had transitioned from a nursing facility to the community. With the group, Greg began to provide peer support to others that were going through the transition process.

## **Case Study for an Elderly Person**

### **Background**

Mrs. Sergor, age 65, has been residing in a New Hanover County nursing home for the past 10 months. Mrs. Sergor and her husband moved to the coast of North Carolina from Charlotte when her husband retired eight years ago. He died suddenly a year and a half ago. She has no relatives living in North Carolina, but she has several friends from church who visit often. Due to her rheumatoid arthritis, Mrs. Sergor had a hip replacement at a Wilmington hospital and transferred to the nursing home for the expected two-week rehabilitation after her surgery. While she was there, she suffered a stroke, leaving her paralyzed on her left side. Mrs. Sergor received extensive rehabilitation and improved, but still needs assistance in bathing, dressing, and getting in and out of a bed or chair. Mrs. Sergor continues to need skilled-level care, but feels she is too young to be in a nursing facility. She was determined to be eligible for Medicaid three months ago.

### **Participant identification**

The Regional Long-Term-Care Ombudsman was invited to speak to the resident council at the nursing facility. After the resident council meeting, Mrs. Sergor spoke with the Regional LTC Ombudsman about her desire to move out of the nursing home. The Regional LTC Ombudsman had information for her regarding Money Follows the Person Grant. The grant can assist individuals in long-term-care facilities to transition out of a nursing home and back into the community. The Regional LTC Ombudsman gave Mrs. Sergor the telephone number for the Money Follows the Person Program Specialist, who is a State employee located in the Division of Medical Assistance in Raleigh. When Mrs. Sergor called the Program Specialist, she was connected with the agency that serves as the transition coordinator in New Hanover County.

### **Prior to the transition**

The transition coordinator in New Hanover County, who is with the Division of Vocational Rehabilitation, Independent Living Section, scheduled an appointment to visit with Mrs. Sergor at the nursing facility. The transition coordinator explained the program in more detail and how the Money Follows the Person Grant could assist Mrs. Sergor in transitioning out of the nursing home into a place of her own. The transition coordinator explained the different living arrangements and service options available to her, including the Program of All-inclusive Care for the Elderly (PACE) or the Community Alternative Program for Disabled Adults (CAP/DA).

The Program of All-inclusive Care for the Elderly is a managed care program in New Hanover County that enables elderly individuals who need nursing facility care to live as independently as possible. The Program of All-inclusive Care for the Elderly service package includes all Medicaid-covered services, as specified in the State's approved Medicaid plan, such as multidisciplinary assessment and treatment planning, social work services, skilled nursing care, primary care physician services, medical specialty services, specialized therapies, recreational therapy, personal care services, nutrition counseling, meals, medical supplies, home mobility aides, transportation, prescriptions, laboratory tests, rays, and other diagnostic procedures, durable medical equipment and corrective vision devices.

CAP/DA also provides services to adults who qualify for nursing facility care so they can remain in their private residences. The services include adult day health care; in-home aide services, level II and level III (includes personal care); supplies such as incontinence supplies, oral nutritional supplements, and medication dispensing boxes; case management, home mobility aids; adaptations to home environments (such as wheelchair ramps, safety rails, grab bars, non-skid surfaces, and so on); preparation and delivery of meals; respite care (both in-home and institutional); telephone alerts; attendant care services; and private duty/independent licensed nursing services. Mrs. Sergor should be able to live independently after the transition with minimal risks if she participates in either the Program of All-inclusive Care for the Elderly or CAP/DA.

With Mrs. Sergor's approval, the transition coordinator arranged a meeting with Mrs. Sergor, the social worker, and the director of nursing at the facility to review Mrs. Sergor's information from the Resident Assessment Instrument (RAI). That would help determine the medical support, personal care, and any other current supports needed to assist Mrs. Sergor in the community.

The transition coordinator began a detailed person-centered plan with Mrs. Sergor by discussing the roles of friends, housing options, health care, personal assistance, home adaptations or assistive technology, transportation, finances, her social and faith activities, and volunteer or employment options. The transition coordinator briefly explained the eligibility requirements for CAP/DA and the Program of All-inclusive Care for the Elderly, and assisted Mrs. Sergor in setting up an appointment with the CAP case manager in the county, who would provide more detailed information.

Mrs. Sergor expressed a desire to move into a housing situation where two meals a day are provided. A senior congregate housing apartment complex in her former neighborhood is close to her church, and a few of her friends from church recently moved there. The rent is based on income so it is an affordable option. The apartment complex regularly transports tenants to the grocery store and shopping malls, and the housing manager can assist in arranging trips for medical appointments. The transition coordinator assisted Mrs. Sergor in contacting the senior housing apartment complex to inquire about the availability of apartments.

### **Transition into community life**

The transition coordinator met with Mrs. Sergor, the social worker at the nursing facility, and a close friend of Mrs. Sergor's to develop a plan to ensure the success of her transition. The social worker at the nursing facility is involved in the planning to ensure that the discharge for Mrs. Sergor is safe and orderly. Mrs. Sergor asked that her close friend sit in on the planning for emotional support.

Mrs. Sergor chose the service package with the CAP/DA. Typically, there is a waiting list for CAP/DA slots in the county, but a person transitioning out of a nursing facility who is participating in the Money Follows the Person Grant is given priority. Mrs. Sergor spoke with the senior housing apartment manager and was informed an apartment would be available in a month. Over the next month, the transition coordinator assisted Mrs. Sergor in securing essential

furnishings for her new home, and also provided security deposits and connection fees for utilities through the Money Follows the Person one-time transition expenses.

Mrs. Sergor expressed a desire for a motorized wheelchair so she would have more mobility and be able to perform volunteer work at her church, which is across the street from her new home. With Mrs. Sergor's permission, the transition coordinator contacted the Aging and Disability Resource Connection to obtain information about other community resources available to assist Mrs. Sergor in obtaining a motorized wheelchair.

The day arrived when her senior housing apartment became available and CAP/DA eligibility was approved. The transition coordinator worked closely with Mrs. Sergor and the facility social worker to ensure that her discharge from the nursing home progressed in an orderly way. The transition coordinator ensured that Mrs. Sergor was able to find a doctor in the community, and that she had a sufficient supply of medications to last before her visit to her new doctor.

### **Transition into a Home- and Community-Based Program**

The transition coordinator met Mrs. Sergor when she arrived at her new apartment, where her church had stocked the small kitchen with groceries. The transition coordinator and the home health agency ensured that the in-home aide reported to work at the same time Mrs. Sergor moved into her new place. They gave Mrs. Sergor telephone numbers of the transition coordinator and the home health agency to contact directly if she has any problems or questions. The transition coordinator also provided Mrs. Sergor with the county department of social services contact information and information on how to report suspected abuse, neglect, or exploitation and the process for reporting critical incidents.

The transition coordinator will visit Mrs. Sergor once a week for a month to see how she is adjusting. The second month, the transition coordinator will visit her two times; and the third month, one time. On her visits to see Mrs. Sergor, she observed that Mrs. Sergor was happy to be able to visit with her friends and enjoyed participating in activities at the senior apartment complex and volunteering at her church.

One day, Mrs. Sergor had a challenge with her in-home aide, who provided her personal care services. The in-home aide failed to show up as scheduled. Mrs. Sergor tried to transfer herself to the wheelchair, but her arms were a little weaker than usual and she panicked. She remembered her emergency response button around her neck and pushed the button. The emergency response system alerted the home health agency and a neighbor who had a key. The neighbor went to the apartment and sat with Mrs. Sergor until the home health agency sent an in-home aide.

## Benchmarks

The North Carolina Money Follows the Person Project will measure five benchmarks—two which are required by CMS and three developed by the State. Given the possible changing needs of the population and understanding that the benchmarks may need to be revised or edited once implementation starts, it is anticipated these could change. North Carolina will assess and provide revised benchmark information to CMS as needed.

**1. *The projected number of eligible individuals in each target group to be assisted in transitioning from an in-patient facility to a qualified residence during each fiscal year of the demonstration***

Projected number of transitioned participants by Federal Fiscal year and population						
	Elderly	Physically Disabled	MR/DD	Mentally Ill	Dual Diagnosis <sup>1</sup>	Total
2008	0	0	0	0	0	0
2009	5	47	11	0	0	63
2010	7	58	15	0	0	80
2011	10	97	12	0	0	119
Total	22	202	38	0	0	262

North Carolina has found it necessary to reduce the number of individuals transitioned from 552 to 262. This directive was given from staff at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The following gives justification for the reduction in numbers:

1. **For MR/DD population:** A review of historical numbers of individuals who have transitioned from a Developmental Center to the community reflects that approximately half of those individuals chose to transition to community Intermediate Care-Mentally Retardation facilities. This in part was due to the significant support needs of the individual. The developmental centers honor the choice of individuals and guardians in determining a community residential setting and these numbers also take into account the choice of individuals and their guardians. In light of this information it was felt appropriate to reduce the targeted number of individuals transitioning to the community from State operated Developmental Centers.
2. **For Mentally Ill population:** The number of children in Psychiatric Residential Treatment Facilities (PRTFs) for over six months is limited and does not justify the original number of children targeted of 42.
3. **For Dual Diagnosis population:** The original intent of targeting this population group for Money Follows the Person was to transition individuals with Intellectual Developmental Disabilities/Mental Illness from state psychiatric hospitals to the community. However, consideration was not given to the fact that Money Follows the Person does not target non-Medicaid funded facilities such as Institutions of Mental Diseases where these individuals may reside.

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<sup>1</sup> Estimated 35% of MR/DD/MI population will have dual diagnosis

## **2. Qualified expenditures for Home and Community Based Services during each year of the demonstration program**

In SFY 2004, North Carolina spent 59% of Medicaid funds on Nursing Facility Care compared to a national average of 75%, placing North Carolina in the top ten states with the lowest proportion of Medicaid spending for nursing facility care. Home- and community-based services have grown steadily over the last five years, from 35.5% to 41.4%. In 2002, the North Carolina General Assembly authorized \$28 million to expand the CAP/DA program, resulting in a 12% increase in home- and community-based services spending.

	Elderly and Physically Disabled CAP/DA & CAP/CHOICE			Mentally Retarded/ Developmentally Disabled CAP/MR-DD		
	Nursing Facility Costs	Home and Community Based Services Costs	Savings	Intermediate Care Facility Costs	Home and Community Based Services Costs	Savings
2009	\$941,872	\$577,887	\$363,985	\$565,497	\$218,457	\$347,040
2010	\$2,221,036	\$1,362,719	\$858,317	\$1,359,177	\$743,521	\$615,656
2011	\$3,274,278	\$2,008,944	\$1,265,334	\$2,998,163	\$1,498,540	\$1,499,623
Total Annual Savings			\$2,487,636			\$2,462,228
Total Project Savings						\$4,949,864

**The following additional benchmarks have been selected by the State:**

### **1. Establishing a trusted, visible, and reliable system for accessing information and services by December 2011.**

The North Carolina Department of Health and Human Services, Division of Aging and Adult Services, received an \$800,000 three-year grant to develop two Aging and Disability Resource Center pilot sites in 2004. The term “Aging and Disability Resource Centers” has been changed in North Carolina to “Aging and Disability Resource Connections” to reflect the building of decentralized, no wrong door models in North Carolina. The purpose of the Aging and Disability Resource Connections is to provide information on the full range of long term care options and to streamline access to long term care services and supports at a uniform point of entry. At this time, there are two pilot sites—one each in Forsyth and Surry counties. The benchmarks provided in the table below summarize expected state-wide expansion of Aging and Disability Resource Connections and the increase in number of individuals served by these centers.

In October 2006, North Carolina Department of Health and Human Services, Office of Long-Term Services and Supports, received a Systems Transformation Grant from CMS. One of the three selected goals is “Improved access to long term care support and services: Development of a one-stop system.” Funds were provided under this grant to expand Aging and Disability Resource Connections. Activities under this grant and activities for Aging and Disability Resource Connections expansion under funding from the Administration on Aging were combined under the Office of Long Term Services and Supports for Department of Health and Human Services. The Aging and Disability Resource Connections serves individuals seeking services and supports for older adults and adults with disabilities. The goals of Aging and Disability Resource Connections are to:

- Streamline and simplify access to long-term services and supports in order to ensure each individual’s need for services is determined and addressed,
- Maximize consumer choice and provide services in a consumer friendly manner, respecting and ensuring the dignity of all served, and
- Creating a more balanced system of long-term services and supports to include more home and community-based services.

Aging and Disability Resource Connections will also be able to provide counseling for long term service options.

North Carolina has also developed a web-based information and referral system called NCcareLink. This is a state-wide system which includes information about services and supports available statewide and will be utilized in all Aging and Disability Resource Connections to assist individuals in identifying long term care services and programs in their part of the state.

<b>Benchmark</b>	<b>Federal Fiscal Year</b>				
	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>	<b>Total</b>
# of Aging and Disability Resource Connections in North Carolina	2	4	5	6	6
# of Individuals served by Aging and Disability Resource Connections	N/A	10,200	12,200	14,000	44,600

Aging and Disability Resource Connections will also have a qualified screener who can utilize the web-based Medicaid Uniform Screening Tool to assist individuals in determining what Medicaid long term care services and supports may be available. This uniform screening program is described in Additional Benchmark #2 below.

**2. Establish processes for screening, identifying, and assessing persons who are candidates for transitioning to the community that are put into use in the general Medicaid program beyond recruitment for the Money Follows the Person demonstration.**

The Division of Medical Assurances and Division of Mental Health, Developmental Disabilities and Substance Abuse Services will employ a variety of methods to identify individuals in various treatment settings who would like to transition to community care. These methods are summarized by population group and facility setting below. Additionally, individuals are encouraged to use self-advocacy as a means of expressing an interest and desire in transitioning to community care. Even though the benchmarks noted here speak towards instruments and/or tools and assessments, individual self-advocacy will be valued and honored as a means of identifying individuals desiring to move from an institution or facility into the community. Assessment(s) of the individual's needs for transitioning will be implemented as outlined in this Operational Protocol after an individual expresses an interest.

**Population Group**

*Individuals who are elderly or physically disabled who have resided in a nursing facility for at least six months.*

The following chart indicates the number of individuals to be identified via various tools and/or organizations.

Federal Fiscal Year	Individuals identified by:				
	Medicaid Uniform Screening Tool	Centers for Independent Living	Long-Term Care Ombudsmen	Voc. Rehab Independent Living Rehabilitation Program	Total
2008	0	0	0	0	0
2009	2	33	16	14	65
2010	3	34	17	14	68
2011	5	46	23	17	91
Total	10	113	56	45	224

In August 2006, North Carolina Division of Medical Assistance entered into a two year agreement with Electronic Data Systems Corporation to develop and implement a web-based Medicaid Uniform Screening Tool for Medicaid long-term care programs, services, and supports. This tool is completed by authorized and trained screeners. Screeners must participate in either the MUST Regional Training or the On-line training. All participants are required to demonstrate competency in the use of the tool as evidenced by passing the MUST Online Test. Ongoing screening will be monitored through several of DMA's quality assurance initiatives. Authority to screen may be revoked if processes are abused.

Eligible Screeners (those completing the MUST form) may include:

- Medical professionals such as:
  - Physicians,

- Physician Assistants, Family Nurse Practitioners, and other mid-level practitioners,
- Registered Nurses and Licensed Practical Nurses,
- Medical/Clinical Social Workers, Qualified Mental Health Professionals and Psychologists.
- Hospital discharge planners and case managers who make referrals to long-term care services and supports.
- Case managers from regional, local and community organizations that make referrals to long-term care services and supports.
- Staff of Aging Disability Resource Centers, Departments of Social Services and other providers, agencies and networks whose entity administrator determines the potential screener has the experience and training with which to complete the screenings.

The Medicaid Uniform Screening Tool provides a comprehensive screening of individuals applying for Medicaid long term care services. The evaluation data (see Attachment A) contains elements relating to medical conditions and needs, prescription drugs, functional limitations, socio-demographics, mental illness, mental retardation and related conditions issues and needs (i.e., Preadmission Screening and Annual Resident Review Screening and Level II Evaluations), cognitive status, mood and behavior, orientation and interpersonal functioning, home environment and caregivers to name some of the most relevant. The Medicaid Uniform Screening Tool, through programmed internal logic, will select three Medicaid programs that are a best fit for the individual and recommend one program as best-fitting of the identified options.

The Medicaid Uniform Screening Tool incorporates level of care reviews and pre-admission screening (as required under the federally-mandated Preadmission Screening and Annual Resident Review regulations) for mental illness, mental retardation, and related conditions. Screened individuals who appear to have treatment needs relating to these conditions are referred for a full Level II mental illness, mental retardation and related conditions evaluation.

The Medicaid Uniform Screening Tool will support nursing facility and special care unit (for Alzheimer's or related disorders) transitions in five ways. Specific elements within the screening domains will:

1. Record the applicant's preference to receive services in a facility, or in the home/community setting;
2. Evaluate the applicant's home environment and availability for capable and willing caregivers;
3. Provide information about whether the applicant can live safely in the community;
4. Determine if the individual has the requisite cognitive capacities, orientation, and interpersonal functioning capabilities for self-directed and chronic disease self-management programs or who has a representative who has the capacities and willingness to assist the person in self-direction/self-management; and
5. Provide the applicant a choice of program and service options based on the level of care required, preferences, and available programs, services, and supports.

Medicaid Uniform Screening Tool will be piloted in September 2008 in hospitals, local Departments of Social Services, and home health agencies with Money Follows the Person

potential participants before being utilized state- and system-wide. It is expected this tool will be implemented by Spring 2009 within Money Follows the Person demonstration grant processes.

### **Population Group**

*Individuals with skilled nursing requirements and mental illness who have resided in nursing homes for at least six months.*

The following chart shows the number of individuals that may be identified through the various tools and/or organizations.

Federal Fiscal Year	Individuals identified by:		
	Preadmission Screening and Annual Resident Review	Centers for Independent Living, Independent Living Rehabilitation Programs, and Ombudsmen	Total
2008	1	1	2
2009	7	2	9
2010	18	5	23
2011	23	6	29
Total	49	14	63

Federal regulations require that all individuals requesting admission to a nursing facility be screened for mental illness, mental retardation, and related conditions. This process will be included in the North Carolina Medicaid Uniform Screening Tool. Currently the Preadmission Screening and Annual Resident Review contractor maintains records of all previous screening and follow-up of Level II mental illness, mental retardation and related conditions assessments. Preadmission Screening and Annual Resident Review screening will be the principle source of information to identify individuals residing in nursing facilities with mental health diagnoses. Other individuals may be identified by agencies and organizations involved in monitoring long term care services (i.e., Ombudsmen) and providing transition-related services (i.e., Centers for Independent Living and Vocational Rehabilitation's Independent Living Rehabilitation Program).

All individuals in this population group will receive an independent living evaluation before a transition plan is developed and implemented.

### **Population Group**

*Individuals who have resided in private or State-operated Intermediate Care Facilities-Mental Retardation (Developmental Centers = State-operated) for at least six months, and individuals who have resided in state and private psychiatric facilities for at least six months.*

The following chart shows the number of persons to be identified annually via the annual person-centered planning meetings.

Federal Fiscal Year	Identified via Annual Person-Centered Planning Meetings
2008	5
2009	42
2010	105
2011	113
Total	265

Each year, individuals receiving Medicaid and state-funded services for developmental disabilities and mental illness, with their families, guardians and/or caregivers, participate in an annual “Person-Centered Planning Meeting.” If the resident or resident’s family or guardian indicates that they are “in favor of” or “not opposed to” community living, the resident is placed on a list and transitioned when housing and services become available.

**3. Expansions to, and improvements in, health information technology (i.e., progress directed by the state to build systems that accommodate the business needs of multiple organizations that serve the targeted populations).**

Benchmark	Federal Fiscal Year				
	2008	2009	2010	2011	Total
# of individuals screened through Medicaid Uniform Screening Program <sup>2</sup>	26,500	106,000	114,500	92,700	339,700
# of “hits” on North Carolina CareLink	12,000	15,000	20,000	20,250	67,250

North Carolina Division of Medical Assistance has planned for and is in the processing of developing two web-based automated long term care program management tools.

The Medicaid Uniform Screening Tool, described above, will make it faster and easier for individuals to be approved for Medicaid long term care services and supports. This system will also support facility transitions, consumer self-directed programs, and chronic disease self-management programs. Since this tool is Internet-based, multiple organizations will have access to data and information required to fulfill their roles in the Medicaid long term care program admission process.

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<sup>2</sup> Based on historical data

## **Participant Recruitment and Enrollment**

Persons who are eligible for home and community based waiver services (CAP-MR/DD, CAP/DA, CAP/Choice) and reside in an eligible institution will be eligible to participate in North Carolina's Money Follows the Person Demonstration grant. The following provides a description of the target populations within North Carolina that will be transitioned during the duration of the Money Follows the Person Demonstration Grant project, as well as the recruitment processes utilized for those target populations.

The target populations selected for transition include aging individuals with care needs and/or disabilities who have been residing in nursing facilities for a minimum of six months; individuals who have been diagnosed with a mental illness and who have resided in nursing facilities or special care units (for Alzheimer's or related disorders) for a minimum of six months; individuals who have been residing in private Intermediate Care—Mental Retardation facilities or state-operated Intermediate Care Facility- Mental Retardation facilities (developmental centers) for a minimum of six months; and individuals with mental illness (includes children/adolescents age 6-17) who have been treated in a state-operated or private psychiatric facility for a minimum of six months and who are eligible for Medicaid 30 days prior to transition.

A detailed person-centered plan<sup>3</sup> (which includes a transition plan) is required to be completed for each individual who qualifies for transition through the Money Follows the Person Demonstration Grant project. Factors to be considered in the transition plan will include:

- Medical issues and resources to meet the identified needs
- Behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- A clear, well documented crisis plan that addresses not only intervention techniques but the prevention processes as well
- Residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members/guardians and informal supports.

Please refer to Marketing, Outreach, and Education section for additional information.

### **Selection Process**

During North Carolina's first year (calendar year 2008) of Money Follows the Person demonstration grant, there will be a limited number of months to transition twenty-one individuals. As a means of ensuring success, individuals (after being determined eligible) will be served based on the extent of the barriers to transition:

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<sup>3</sup>The use of person-centered planning principles is being encouraged in all divisions within North Carolina Department of Health and Human Services for their day-to-day operations and use in policy development. Participation of agency's staff in developing these principles has truly been effective in helping the Department of Health and Human Services to make policy changes. This information was distributed in August 2007. It will take time for systems to change where this terminology is used consistently and across the board in all divisions. In the meantime, 'plan of care' will be seen in written documentation until such revisions and/or amendments are made. Specifically, within this document, both phrases will be seen and the reader is advised to understand there will be a gradual, systematic change to the use of 'person-centered planning' and the principles around this important concept.

- *None:* Consumer is interested and has minimal/limited barriers, or barriers can be easily overcome, AND guardian or legal representative (if there is one) is supportive of discharge
  - *Limited:* Consumer is interested, but has barriers that will take some time to resolve OR guardian or legal representative (if there is one) is not supportive, or aware, of options available upon discharge.
  - *Moderate:* Consumer is not interested, but has barriers that can be overcome and guardian or legal representative (if there is one) may or may not be supportive
  - *Significant:* Consumer is unable to overcome the barriers to discharge (i.e., specific medical issues that cannot be met in settings that the consumer is willing to consider with services available informally, in the community and under home and community-based services) OR consumer cannot express interest because of severe cognitive limitations and guardian or legal representative (if there is one) is not interested in another setting.
- In all cases, the individual's family will be considered if the individual has provided permission for the family to be involved.

The Program Specialist will be a State employee who oversees, coordinates, and manages the process of individuals from agencies assisting clients as they prepare for transition to the community. The Program Specialist will have experience and skills in transitioning individuals from facilities and institutions into the community. The Program Specialist will be located in the Division of Medical Assistance office in Raleigh, North Carolina. In each community, staff and advocates from Centers for Independent Living, Division of Independent Living Rehabilitation Program, Association of Self Advocates, Real Advocates Now Emerging, and others will work directly with individuals who express a desire to transition out of a facility. The Program Specialist will serve as a resource in locating services, etc. Regional Ombudsmen from the North Carolina's Division of Vocational Rehabilitation Services—Independent Living will provide information regarding Money Follows the Person during mandated, quarterly visits to nursing facilities for those who express an interest in moving into the community.

#### ***Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility***

To qualify for transition, individuals must have resided in the facility for a minimum of six months and be eligible for Medicaid 30 days prior to transition. The target region for this population is the entire state.

Individuals expressing a desire and interest to transition out of a nursing facility will review and discuss with their families/guardians and the transition coordinator, information from the Minimum Data Set or any other assessment tool used by the facility to determine medical support, personal care, and other supports available to meet the individual's needs for transitioning to a qualified residence.

Transition coordinators will facilitate the process of identification through contact with the Regional Long Term Care Ombudsmen and/or Centers for Independent Living staff. The agency's transition coordinators will provide information to consumers and their families/guardians/caregivers to ensure an understanding of the Money Follows the Person Demonstration Grant project and the target population focus. This information will be provided in written and verbal form and will include information regarding the project itself, community

residential options to nursing home placement, and support services available to maintain the individual within the community.

***Individuals Who Are Residing in State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)***

Guardians of individuals residing in state-operated Intermediate Care–Mental Retardation facilities who have indicated through a standardized survey (**Attachment B**) an interest in their family member moving into community living will be provided information on Money Follows the Person Demonstration grant project. At the annual person-centered planning/plan of care meeting, community living options will be discussed. The surveys were administered late 2007/early 2008 by developmental center staff. Throughout the demonstration project (2008-2011), as residents and guardians express a desire for community living, the survey may be administered.

***Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities***

A survey for use in private Intermediate Care–Mental Retardation facilities—similar to the survey given to those in state-operated Intermediate Care–Mental Retardation facilities mentioned above—will be developed and administered to identify individuals desiring to move into the community from facilities (see Attachment B1). Disability Rights North Carolina funded a pilot Volunteer Monitoring Project in Durham, North Carolina at which time individuals were identified who wanted to transition to the community. Development of a similar process is underway with Money Follows the Person Project Director and advocates who administered the above mentioned survey. This process will be used state-wide in private Intermediate Care–Mental Retardation facilities.

Transition coordinators will provide information to individuals surveyed and their guardians regarding Money Follows the Person Demonstration Grant project and their choice of community placement. This information will be provided in written and verbal form and will include information regarding the project itself and community residential options versus institutionalization, as well as services and supports available in the community that can be used so that the individual is able to remain within the community. Those individuals and their guardians (or family members with permission) who express an interest and desire to transition to the community will be the focus of the transition process during the first year of the demonstration (2008).

**Qualified Institutional Settings**

***Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility***

Qualified institutional settings include skilled nursing facilities and special care units (for Alzheimer's or related disorders) throughout the State.

***Individuals Who Are Residing in Private or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers = State-operated))***

Qualified institutional settings include private Intermediate Care—Mental Retardation facilities and state-operated facilities (developmental centers) throughout the State.

**Note:** The short-term specialty programs at the developmental centers are exempt from the Money Follows the Person Demonstration Grant project.

### **Residency Requirements**

#### ***Individuals who have Care Needs and/or Disabilities Residing in a Nursing Facility***

The transition coordinator will be responsible for ensuring, through contact with the administrator and staff of the facility, that the individual assessed for transition to the community has been residing in the nursing facility for at least six months. This will be documented via an admission summary.

#### ***Individuals Who Are Residing in Private or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers = State-operated)***

The transition coordinator will be responsible for ensuring through the director and staff of the facility that the individual assessed to transition to the community has been residing in the developmental center or intermediate care facility for at least six months. This will be documented via an admission summary.

### **Process for Assuring Medicaid Eligibility**

The transition coordinator will be responsible for ensuring that the individual who will be participating in the Money Follows the Person Demonstration Grant project continues to be eligible for Medicaid upon discharge from the facility. As applicable, hospital social workers, the developmental center's or Intermediate Care–Mental Retardation group home's reimbursement office and nursing facility discharge planners work in collaboration with the individual's local Department of Social Services in the specific county in which the individual resides to obtain documentation verifying Medicaid eligibility.

### **Enrollment**

All individuals who wish to participate in the Money Follows the Person Demonstration Grant project, or if appropriate, the individual's legal guardian or representative, will be asked to sign a consent form (see **Attachment C**) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants and/or their family/guardian will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

### **Re-enrollment Policy**

A Money Follows the Person participant who is re-institutionalized for a period *greater than 30 days* will be categorized as **disenrolled** from the program. However, a disenrolled individual may re-enroll in the program without re-establishing the 6-month institutional residency requirements. As long as a former participant meets Medicaid waiver eligibility criteria, the participant will still be eligible for Money Follows the Person services at the enhanced Federal Medicaid Assistance Percentage match. However, if the former participant remains in the qualified institution beyond 6 months, the participant will be defined as a "new" Money Follows

the Person participant in terms of the Money Follows the Person services and the Federal Medicaid Assistance Percentage.

A former participant may re-enroll in the program after being re-evaluated and after having an updated Plan of Care. Once the individual is assessed to be appropriate for home and community based services services, a referral will be made to the case manager for development of the individualized Plan of Care that addresses any change in the status of the Money Follows the Person participant and/or any lack of necessary supports in the community. After three incidences of re-institutionalization of 30 days or longer, the re-institutionalized Money Follows the Person participant will not be considered for reentry into the Money Follows the Person project.

***Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility***

In order to be considered for re-enrollment, an assessment must be completed to determine if adequate community resources are available to meet the medical needs of the individual. This will include verification by the transition coordinator of ongoing access to medical care specific to the needs of the individual.

***Individuals Who Are Residing in Private Intermediate Care– Mental Retardation Facilities or State-operated Intermediate Care– Mental Retardation Facilities (Developmental Centers)***

In order to be considered for re-enrollment, a detailed person-centered plan including a transition plan is required to be completed by a team of individuals consisting of developmental center staff, Local Management Entity staff, and community providers with specific processes to ensure community sustainability. (Person-centered planning tools such as Essential Lifestyle Planning or Making Action Plans may be used.) Factors to be considered in the transition plan will include:

- medical issues and resources to meet the identified needs
- behavioral challenges and resources to address the needs including development of a behavior support plan with ongoing oversight and training by a licensed psychologist
- a clear and well documented crisis plan that addresses not only intervention techniques but prevention processes
- residential setting issues and assurances of appropriate staff and resources, including training of staff and/or family members and informal supports

## **Informed Consent and Guardianship**

All individuals who wish to participate in the Money Follows the Person Demonstration Grant project (or, if appropriate, those individuals' legal guardians) will be asked to sign a consent form (see **Attachment B**) indicating that they have freely chosen to participate, are aware of and understand the transition process, have full knowledge of the supports and services to be provided, and have been informed of their rights and responsibilities as participants. Additionally, participants and/or their family members and/or guardians will be informed about the State's protections from abuse, neglect, and exploitation and the process for reporting critical incidents.

### **Informed Consent**

#### ***Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility***

Informed consent for participation in the Money Follows the Person Demonstration Grant project may be provided by the adult participant, emancipated minors, the parents of minors, or the legal representative or surrogate decision makers who have responsibility for individual's living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent named in a health care power of attorney. In cases where there is a legal representative or surrogate decision maker, the transition coordinator will review appropriate legal documentation to ensure that the individual possesses the legal authority to make decisions dealing specifically with a participant's living arrangement and receipt of services/treatment.

#### ***Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities or State-operated Intermediate Care Facility-Mental Retardation Facilities (Developmental Centers)***

Informed consent must be provided by the participant, unless that participant has been adjudicated as unable to make major life decisions. In that case, informed consent must be provided by the court-appointed guardian.

### **Guardianship**

Chapter 35A of the North Carolina General Statutes contains the state's laws dealing with guardianship. In North Carolina, each of the state's 100 counties has a clerk of superior court who determines the appropriateness of guardianship and appoints a guardian if needed. Guardians are considered surrogate decision makers for individuals who may no longer be capable of making and communicating decisions about themselves and/or their assets. The guardian's duty is to advocate for and assist the ward in exercising his or her rights.

A guardian may be an individual, such as a family member or friend; a corporation chartered to serve as guardian; or a disinterested public agent guardian. A disinterested public agent guardian may be the director or assistant director of a local human services agency (local Department of Social Services, Local Management Entity, local health department, or county department on aging) or an adult officer or agent of a state human services agency.

While North Carolina General Statute 35A does not specify the level of interaction between a ward and an individual or corporation serving as guardian, it does speak to the rights of the individual and the guardian/ward. Specifically, North Carolina General Statute 35A-1201(5)

reads, “Guardianship should seek to preserve for the incompetent person the opportunity to exercise those rights that are within his comprehension and judgment, allowing for the possibility of error to the same degree as is allowed to persons who are not incompetent. To the maximum extent of his capabilities, an incompetent person should be permitted to participate as fully as possible in all decisions that will affect him.” Additionally, North Carolina General Statute 35A-1241, Powers and duties of guardian of the person, (a)(2) states, “The guardian of the person may establish the ward’s place of abode within or without this State. In arranging for a place of abode, the guardian of the person shall give preference to places within this State over places not in this State. The guardian also shall give preference to places that are not treatment facilities. If the only available and appropriate places of domicile are treatment facilities, the guardian shall give preference to community-based treatment facilities, such as group homes or nursing homes, over treatment facilities that are not community-based.”

The General Statute also does not address how frequently a guardian must visit with a ward. Disinterested public agent guardians are required by North Carolina Administrative Code to have contact related to the ward no less than once every 90 days. Corporations and disinterested public agent guardians submit annual status reports to the clerk of court’s office, detailing what has been done for the ward during a specified time period. These reports include the level of interaction between the guardian and the ward.

In regard to the Money Follows the Person Demonstration Grant project, legal representatives or surrogate decision makers who have responsibility for individual’s living arrangement, such as guardians, an attorney-in-fact named in a durable power of attorney, and a health care agent appointed by the individual within the project, will be required and agree to have contact with the individual identified for transition within the last six months. Only a court-appointed guardian may act as guardian or other legally appointed representative for the participant. Corporations and legal guardians other than family members will follow their agency (such as local Department of Social Services or Local Management Entity) protocol for ensuring ongoing guardian interaction.

### **Training and Information**

#### ***Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility***

Each individual identified for transition to the community will be provided with information regarding protection from abuse, neglect, and exploitation and the process for notifying the appropriate authorities if the participant is subject to abuse, neglect, or exploitation. This information will be given by the transition coordinator to the individual as well as to other identified family members, legal guardians, etc., during the person-centered planning process.

#### ***Individuals Who Are Residing in Private Intermediate Care– Mental Retardation Facilities or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)***

Each individual identified for transition to the community and, where applicable, his or her guardian or legal representative, will be provided with information regarding protection from abuse, neglect, and exploitation in the community and how to notify the appropriate authorities if the participant is subjected to abuse, neglect, or exploitation. The information will be reviewed with the individual and his or her guardian and/or legal representative by the individual’s

planning team during the person-centered planning process and at any time a transition meeting is taking place (should the desire to transition occurs prior to the annual person-centered planning process).

Processes for ensuring protection from abuse, neglect, and exploitation include the following. Transition coordinators, in collaboration with the Local Management Entity, will be responsible for training the individual and legal guardians in this system to respond to and report critical incidents and other processes.

- The North Carolina Administrative Code requires all Local Management Entities and provider agencies to participate in a Division of Mental Health/Developmental Disabilities/Substance Abuse Services coordinated system for responding to and reporting critical incidents and other life-endangering situations. This system addresses deaths, injuries, behavioral interventions (including physical restraints), management of medications, allegations of abuse or neglect, and consumer behavior issues.
- Service providers are required to respond to all incidents by
  - ensuring the safety of consumers and others,
  - documenting the incident and steps taken to remedy the situation, and
  - analyzing incident trends as part of the agency's quality improvement process.
- Incidents are divided into three levels of severity, which determines the intensity and breadth of the response:
  - Level I includes incidents that are already being addressed clinically and/or have limited immediate adverse consequences as isolated events, but that can signal the potential for more serious future problems if not addressed.
  - Level II includes incidents with immediate or potentially serious adverse consequences to the consumer or others, including such events as injuries, abuse allegations, and use of restrictive interventions.
  - Level III includes incidents with the most severe and permanent consequences—death or permanent impairment. In addition to the steps taken for all levels, within 24 hours providers must convene a team to address immediate needs regarding the safety and well-being of consumers, prevent continued or recurring damage from the event, and notify the consumer's guardian and the Local Management Entity of steps taken.
- Provider agencies handle level I incidents internally and make quarterly reports of aggregate numbers of level I incidents, identified trends, and activities being undertaken to address identified problems to the Local Management Entity.
- Provider agencies report level II incidents to the Local Management Entity within 72 hours. The Local Management Entity reviews these incidents to ensure that the provider is taking the necessary actions to keep consumers and others safe, to minimize the recurrence of the incident in the future, and to make the required reports to other authorities.
- When there is reason to believe that an individual has been abused, neglected, or exploited and is in need of protective services, the incident is also reported to the

- local Department of Social Services and to the State Health Care Personnel Registry for investigation. Criminal acts are also reported to legal authorities for investigation.
- Provider agencies report level III incidents to both the Local Management Entity and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services within 72 hours (or immediately if a death occurred within 7 days of seclusion or restraint of the individual).
  - Local Management Entities report information on level II and III incidents to the Division of Mental Health/Developmental Disabilities/Substance Abuse Services quarterly, including aggregate numbers of types of incidents, local trends identified in the Local Management Entity's analysis, and actions they have taken to prevent future incidents.
  - The Division of Mental Health/Developmental Disabilities/Substance Abuse Services ensures that individuals receive support to exercise their rights and voice complaints. The Local Management Entity is the local hub for receiving complaints about service provision.
  - In addition, per administrative rule, each area board for the Division of Mental Health/Developmental Disabilities/Substance Abuse Services or Local Management Entity services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well.
  - North Carolina General Statute 122C-64 states that the Client Rights Committee is responsible for protection of client rights and includes provisions regarding confidentiality, right to treatment and consent to treatment, use of corporal punishment, use of physical restraints or seclusion, and protection from abuse and exploitation.
  - The Local Management Entity Client Rights Committee reviews incidents and consumer complaints, including alleged violations of the rights of individuals or groups; cases of alleged abuse, neglect, or exploitation; concerns regarding the use of restrictive procedures; and failure to provide needed services that are available. The Committee reviews incidents occurring within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action.
  - The Committee makes recommendations to the Local Management Entity board and may report to the local Department of Social Services and other applicable licensing agencies, such as the Division of Health Services Regulation and the Division of Public Health.
  - The Community Services Customer Rights team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainants and consumer information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts.
  - Locally mortality reviews are conducted by the Quality Improvement Committee of the Local Management Entity.
  - The Performance Contract with Local Management Entities requires that Local Management Entities produce reports and use them for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends. Trends related to consumers include incidents and client rights. Local Management Entities must report quarterly all incidents and deaths as well as complaints as part of

the Performance Contract with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services.

**Responsible Entities**

***Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility***

The transition coordinators, in collaboration with the local Department of Social Services adult protective service worker, will be responsible for providing the individual (and his or her legal guardian(s), if applicable) with local information regarding whom to contact and how to report suspected abuse, neglect, or exploitation and the process for reporting critical incidents.

***Individuals Who Are Residing in Private Intermediate Care–Mental Retardation Facilities or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)***

Transition coordinators, in collaboration with the Local Management Entity, will be responsible for providing the individual (and his or her legal guardian(s), if applicable) with local information regarding to whom to make protective services reports and the process for reporting critical incidents.

## **Outreach, Marketing, and Education**

To support the successful implementation of the Money Follows the Person Demonstration Grant project, generic outreach and marketing materials will be developed to be used across a wide range of audiences and locations. A general information sheet template (**Attachment D**) will be available to all audiences. State staff may edit this template for use with specific audiences. Additionally, a flow chart template will be developed to explain the transition process. This template may also be edited to suit various audiences.

### **Participants**

Participants in the Money Follows the Person Demonstration Grant project are those who have expressed an interest in transitioning and who wish to live and receive supports and services in the community of their choosing. Interest in transitioning would have been gained through the methods noted in Participant Participation and Enrollment. Information is disseminated to participants in several stages: pre-transition, post-transition, and ongoing. During the pre-transition stage, potential participants will be notified about the opportunity to transition to the community. During the three months after the transition and on an ongoing basis, participants will be notified of additional services and supports in the community. Participants, potential participants, and/or guardians will be kept informed of services available through the Money Follows the Person demonstration grant throughout the project.

### **Providers**

Providers in the Money Follows the Person Demonstration Grant project are those public, private, and community organizations that will provide services and supports to the participants so that they are able to successfully transition to and remain in the community. There are a wide variety of providers with multiple interests. Many providers have already been notified of the Money Follows the Person Demonstration Grant project. A provider workgroup has been formed; its members have been involved in reviewing the protocol and will continue to be involved through the life of the project. A mass mailing will also be designed for providers to make them aware of the Money Follows the Person Demonstration Grant project and the opportunities for involvement. Examples of service providers across the state are

- Community providers of waiver services
- Professional caregivers
- Nursing home administrators
- Health care workers at agencies providing waiver services
- Community Mental Health Centers
- Centers for Independent Living
- Aging and Disability Resource Connections

During the public forums and stakeholder events being held for CAP waiver renewal information dissemination, the community at large will have the opportunity hear about Money Follows the Person demonstration grant benefits and services. During these meetings, which are planned for May 2008, Money Follows the Person staff will be available to present information and answer questions regarding the demonstration project.

## **State Staff**

State staff refers to the employees of the North Carolina Department of Health and Human Services (Department of Health and Human Services) who will be involved in the Money Follows the Person Demonstration Grant project. A wide variety of staff and Department of Health and Human Services divisions are touched by this initiative. Examples of State agency divisions are

- Department of Health and Human Services
- Division of Medical Assistance
- Division of Aging and Adult Services
- Division of Vocational Rehabilitation Services
- Office of Long-Term Services and Supports
- Department of Health and Human Services—Office of Housing
- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

## **Other**

Advocacy groups also serve as important audiences for Money Follows the Person Demonstration Grant project information. The Division of Medical Assistance will design a mass mailing, using postcards to provide basic information about the Money Follows the Person Demonstration Grant project to various advocacy groups. Examples of advocacy groups across the state are

- North Carolina Council on Developmental Disabilities
- Centers for Independent Living
- disAbility Rights and Resources
- Carolina Legal Association
- Coalition on Aging
- Friends of Residents
- Health Care Faculties Association
- Home Care Association
- Long-Term-Care Regional Ombudsman
- Mental Health Consumers Association
- National Alliance on Mental Illness
- Real Advocates Now Emerging
- Association of Self Advocates
- Disability Rights and Resources (Charlotte, North Carolina)

## **Types of Media to be Used**

### ***Participants***

Participants may receive information on Money Follows the Person demonstration grant services via brochures, broadcast messages (television or radio), in-person-visits to nursing facilities and institutions, Medicaid card inserts, and the Division of Medical Assistance's website at <http://www.ncmfp.com>. Information will also be available on tapes, CDs, videos, and other formats. Media press releases may also be used.

### ***Providers***

Providers may receive information using the following media: Division of Medical Assistance bulletins (e-postings), Money Follows the Person Demonstration Grant project information sheet, Division of Medical Assistance website, remittance advice banner messages, verbal recordings that providers hear while on telephone hold with the Division of Medical Assistance, mass mailings (post cards) to provider associations, and inserts in conference “swag bags.”

### ***State Staff***

State staff may receive information via the Division of Medical Assistance website, fact sheets, and training sessions.

### **Specific Populations to Be Targeted**

#### ***Aging Individuals Who Have Care Needs and/or Disabilities and Who Reside in a Nursing Facility***

Facilities throughout the state will be targeted through nursing facility transition coordinators with the Centers for Independent Living and the North Carolina Division of Vocational Rehabilitation Services Independent Living Rehabilitation Program.

#### ***Individuals Who Are Residing in Private or State-Operated Intermediate Care–Mental Retardation Facilities***

Private Intermediate Care–Mental Retardation Facilities and state-operated facilities (developmental centers) throughout the state will be targeted.

#### ***Individuals (and Their Legal Representatives) Who Are Residing in State-operated Psychiatric Hospitals***

- Cherry Hospital
- Broughton Hospital
- Dorothea Dix/John Umstead/Central Regional hospitals

### **Information Dissemination**

The following resources will be used for information dissemination:

- Aging and Disability Resource Connections
- Various non-profit health care organizations, including
  - National Multiple Sclerosis Society
  - ARC of North Carolina
  - Easter Seals/UCP of North Carolina
  - National Alliance on Mental Illness
  - Mental Health Association
  - Provider associations
- Local management entities (including Community and Family Advisory Committees)
- North Carolina Family Resource Line
- Centers for Independent Living
- Rehabilitation centers
- Nursing facilities
- North Carolina Division of Vocational Rehabilitation Independent Living program offices

- Senior Health Insurance Information Program/North Carolina Senior Medicare Patrol
- Long-Term-Care Ombudsmen offices
- North Carolina Council on Developmental Disabilities
- Providers of Programs for All-inclusive Care for the Elderly (PACE)
- Lead agencies for the CAP/DA
- disAbility Rights North Carolina
- Local libraries
- Community spaces (example: Parks and Recreation centers)

### **Staff Training**

Annual training for Money Follows the Person services will be provided for stakeholders. This would include those who assist in transitioning individuals, those working with CAP waiver services and benefits, information technology staff, and staff from agencies providing transition services. This training will be videotaped, and each person who participated in the training will also have a six-month refresher session/video update.

Other options for training include conference calls and Web-based training activities. These will be scheduled regularly and/or as needed.

Continuing Education Units should be offered to nursing facility staff, referring agencies, and others. This was demonstrated to be a successful technique during North Carolina's Nursing Home Transition grant.

### **Bilingual Materials/Interpretation Services**

Materials will be available in English, Spanish, Braille, and large print. Electronic materials will be accessible to those who use screen readers.

### **Informing Eligible Individuals of Cost-Sharing Responsibilities**

All materials intended for use by participants and their family, friends, and guardians will include language that indicates the responsibility of the individual to participate in cost sharing (deductible), if applicable.

## Stakeholder Involvement

On September 17, 2007, a Money Follows the Person Project kick-off meeting was held to inform stakeholders and State staff about the project. This meeting gave an overview of the project; described the funders' (CMS) role; and provided information on how the Operational Protocol would be developed. Dates for Town Hall meetings were announced and participants were encouraged to attend to provide input into the development of the Operational Protocol and service delivery.

### Stakeholder Chart

Stakeholder involvement is acquired through various committees and workgroups. The Money Follows the Person Demonstration grant is overseen and administered by the Department of Health and Human Services. Leadership from the Department of Health and Human Services is represented on the **Executive Committee**, which sets policy and resolves issues. The **Stakeholders Advisory Group** helps structure the development and implementation of benefits and service deliveries of the Money Follows the Person Demonstration grant in ways that address the needs of stakeholders. Stakeholders are identified as consumers, families of consumers (which together comprise 60% of the membership), providers, and advocates of services provided through Money Follows the Person grant (which together comprise 40% of the membership). (See Consumer Involvement, below, for more detail.) The **State Workgroup** developed the Operational Protocol, implements the benefit package, and responds to the administrative requirement for the project. The **Demonstration Workgroups** are comprised of providers, consumers, advocates, and staff to provide specifics on system issues facing long-term-care services delivery and needed changes. See **Attachment E**.

### Consumer Involvement

Consumers, advocates, and others were invited to participate in six demonstration workgroups as a prerequisite to developing the Operational Protocol for the Money Follows the Person Demonstration Grant project. As the protocol was developed, this group was consulted and was provided with an opportunity to review and comment on the draft.

Town Hall meetings were held across the state to solicit input into the development, implementation, and evaluation of Money Follows the Person. The meetings were advertised with letters sent to long-term-care services consumers, consumer advocates, Local Management Entities, County Department of Social Service Directors, and long-term-care services providers. The letters asked recipients to share the invitation with other stakeholders they knew. From these meetings, information was compiled and integrated into the Operational Protocol and will be considered as services are implemented.

Additionally, consumers, families of consumers, providers, and advocates were asked to participate in an application/nomination process for participation in ongoing Stakeholder Advisory Group meetings (see above). Members are defined as consumers and/or family members of consumers who receive publicly financed long-term-care services; agencies or providers; or representatives of people who are aging with care needs, have an intellectual or other developmental disability, have a physical disability, have a mental illness, or have a dual (or multiple) diagnosis. This group will meet four to six times per year.

### **Provider Involvement**

Institutional providers, consumers, advocates, and State staff were invited to participate in provider issues workgroups. These providers will also be asked to participate in ongoing Stakeholder Advisory Group meetings.

### **Roles and Responsibilities**

The stakeholders will be responsible for providing input to the six workgroup focus areas as well as to provider issues. An orientation to Money Follows the Person project components and deliverables was provided at the initial meeting of each workgroups and stakeholder group. At least one meeting was held for each workgroup focus area during development of the Money Follows the Person Operational Protocol; many groups met several times, and information was obtained through e-mails and telephone calls as well. During the implementation phase of the demonstration project, stakeholders at all levels will be responsible for providing input to the six workgroup focus areas and workgroups will meet on as needed. The six workgroup focus areas are

- Participant Recruitment/Enrollment/Informed Consent/Guardianship
- Housing
- Outreach, Marketing, and Education
- Provider Issues
- Benefits/Services/Consumer Supports/Self-Direction
- Quality Assurance/Continuity of Care

### **Operational Activities**

Each year, the Division of Medical Assistance will coordinate four state forums to be held in conjunction with the Quarterly Stakeholder Advisory meetings. These meetings will rotate to locations around the state. These forums will be open to the public and efforts will be made to invite a wide range of potential participants; their families, friends, and guardians; providers; State staff; and other important community stakeholders.

## **Benefits and Services**

### **Service Delivery Systems**

In North Carolina, the Money Follows the Person Demonstration Grant project will be used to transition individuals into existing 1915(c) home and community based waiver programs. A separate demonstration 1915(c) waiver will not be created for the ongoing services provided through the Money Follows the Person Demonstration Grant project. After 365 days of demonstration services, individuals will continue in the same 1915(c) waiver program as long as they meet the eligibility requirements of the program.

North Carolina currently operates two 1915(c) waivers that target individuals who are aging and/or have disabilities as an alternative to residing in a nursing facility: CAP/DA and CAP/Choice. North Carolina also operates a 1915(c) waiver that targets individuals with intellectual or developmental disabilities as an alternative to residing in a private Intermediate Care Facility-Mental Retardation or a state-operated Intermediate Care Facility-Mental Retardation (developmental center): CAP/MR-DD.

Referrals to CAP/DA and CAP/Choice come from hospitals, Department of Social Services, provider agencies, advocacy groups, friends, family, nursing facilities, senior centers, Area Agency on Aging, and other sources. The majority of referrals come from Department of Social Services and hospitals. Upon referral, if there is no waiting list, eligibility is determined and if eligible, a program assessment is performed and a plan of care/person-centered plan is developed. CareLine, Aging and Disability Resource Connections (where available) can link consumers to CAP/DA and CAP/Choice lead agencies.

CAP/DA and CAP/MD-DD waivers are currently in the renewal processes. Services and benefits under the renewal waiver will be revised to include all supplemental services offered under the demonstration grant. Focus groups are being held during the month of May 2008 as an effort to include needed comments regarding services and benefits from State staff, providers, consumers, and the community at large. The CAP/Choice renewal waiver was approved March 2008 with services retroactive to January 2008 and includes the supplemental benefits and services proposed under the demonstration grant.

Division of Medical Assistance also operates a 1915(b) and (c) waiver, Piedmont Behavioral Health Plan, which provides behavioral health and substance abuse services as the Piedmont Cardinal Health Plan, as well as services to individuals who have intellectual/developmental disabilities as the Piedmont Innovations Program. This waiver is provided to recipients in Cabarrus, Davidson, Rowan, Stanly, and Union counties.

The chart below describes the services currently covered under existing CAPs. Additionally, the last column provides information regarding services that will be covered under the demonstration program. The target population consists of North Carolina individuals who are currently residing in institutional care for a period of 6 months or more from one of the following categories:

- Developmental disabilities
- Elderly and chronically ill
- Physically disabilities
- Acquired brain disorders
- Behavioral health

	Currently Covered Services			Recommendation to Provide as Waiver Service
	Piedmont Innovations; CAP/MR-DD	CAP/DA	CAP/Choice	
Adult Day Health Care	YES	YES	YES	YES
Augmentative Communications	YES \$10,000/year limit	NO	NO	YES
Case Management	YES	YES	NO	NO
Day Supports	YES	NO	NO	YES
Home and Community Supports	YES	NO	NO	YES
Home Modifications	YES \$15,000 limit over waiver duration (3-year period)	YES	YES	YES
Individual/Caregiver Orientation/Training/Education	YES	NO	NO	YES
Personal Care Services/In-home Aide Services	YES (Personal Care Services & Enhanced Personal Care Services)	YES (In-home Aide Services)	YES	YES Expand to include
Personal Emergency Response Services/Telephone Alert	YES	YES (Telephone Alert)	YES	YES
Residential Supports (Group Homes)	YES	NO	NO	YES
Respite Care (In Home)	YES	YES	YES	YES
Enhanced Respite Care	YES	NO	NO	YES
Institutional Respite Care	YES	YES	YES	YES
Non-institutional Respite Care	YES	NO	NO	YES
Specialized Consultative Services (psych counseling, therapy counseling, nutrition counseling, etc.)	YES	NO	NO	YES
Specialized Equipment (Home Mobility Aids)	YES (Specialized Equipment) \$1500/year limit	YES (Home Mobility Aids) \$1500/year limit	YES	YES
Employment Support	YES	NO	NO	YES
Non-medical Transportation	YES (\$1200/yr limit)	NO	NO	YES
Vehicle modifications	YES \$15,000 limit over waiver duration (3 year period)	NO	NO	YES
Waiver Supplies	NO	YES	YES	YES
Hospice Care	NO	NO for Medicaid only YES for dually eligible	NO for Medicaid only YES for dually eligible	YES
Consumer-directed Care Advisor	NO	NO	YES	YES
Financial Management	NO	NO	YES	YES
Consumer-directed Goods and Services (equipment and services not covered through State Plan that are needed to increase ability to complete activities of daily living and instrumental activities of daily living and to decrease dependence on aide services)	NO	NO	YES \$600/year limit	YES

## **Service Package**

### ***CAP/DA***

The Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults (age 18 and older) who qualify for nursing facility care to remain in their private residences. The current CAP/DA waiver provides services and supports to individuals who meet the nursing facility level of care who can be safely and effectively served in the community. Services include:

- Adult day health care
- Case Management
- Home Mobility Aids—adaptations to home environment (such as wheelchair ramps, safety rails, grab bars, non-skid surfaces, etc.)
- In-home aide services, level II and level III (includes personal care; attendant care services)
- Preparation and delivery of meals
- Respite care, in-home
- Respite care, institutional
- Telephone alert (phone line system)
- Private duty/independent nursing service(s)—licensed
- Waiver Supplies: incontinence supplies, oral nutritional supplements, medication dispensing boxes

### ***CAP/Choice***

The Community Alternatives Program Choice (CAP/Choice) is a program of consumer-directed care for aging and disabled adults (age 18 and older) in four counties: Cabarrus, Duplin, Surry, and Forsyth, who qualify for nursing facility care to remain in their private residences.

CAP/Choice provides the individuals with increased control over their services and supports and provides the ability to more fully direct their care. CAP/Choice provides the individuals with more flexibility in tailoring their plans of care to their home care requirements. In addition to the services provided through the CAP/DA waiver, CAP/Choice participants have access to:

- Consumer-directed care advisor
- Consumer-directed financial management
- Consumer-directed goods and services (equipment and services not covered through the State Plan that are needed to increase the individual's ability to complete activities of daily living and to decrease dependence on aide services)

**Note:** Because CAP/Choice provides consumer-directed care advisors, case management is not a direct service component of the waiver.

### ***CAP/MR-DD***

The Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP/MR-DD) provides community services to individuals of any age who qualify for care in an intermediate care facility and individuals who have intellectual disabilities (mental retardation) (Intermediate Care Facility-Mental Retardation). Services include:

- Targeted case management
- Adult day health care

- Augmentative communications (purchase and repairs/service)
- Crisis services
- Day supports (group or individual)
- Home and community supports (group or individual)
- Home modifications
- Individual caregiver training and education
- Personal care services
- Personal care services—enhanced
- Personal emergency response service (PERS)
- Residential supports
- Respite care, enhanced
- Respite care, institutional
- Respite care, non-institutional nursing-based (registered nurse, licensed practical nurse)
- Specialized consultative services
- Specialized equipment and supplies
- Supported employment (group or individual)
- Transportation, non-medical
- Vehicle adaptations

### ***Piedmont Cardinal Health Plan/Piedmont Innovations Waiver***

Piedmont Cardinal Health Plan is a prepaid managed care plan administered by Piedmont Behavioral Healthcare, a public mental health, developmental disabilities, and substance abuse services organization. Piedmont Cardinal Health Plan includes all Medicaid-covered mental health and substance abuse services as well as the new Piedmont Innovations waiver program, which replaces CAP/MR-DD in the five-county area—Cabarrus, Davidson, Rowan, Stanly, and Union. PCHP also includes intermediate care facilities for the individuals who have intellectual disabilities and psychiatric inpatient hospitalizations.

### ***Program of All-Inclusive Care for the Elderly (PACE)***

The Program of All-Inclusive Care for the Elderly is a managed care program that enables elderly individuals who are certified to need nursing facility care to live as independently as possible. The Program of All-Inclusive Care for the Elderly provider receives monthly Medicare and/or Medicaid capitation payments for each eligible enrollee. The Program of All-Inclusive Care for the Elderly provider assumes full financial risk for participants' care without limits on amount, duration, or scope of services.

Effective February 1, 2008, to enroll in this program, an individual must be Medicaid eligible and;

- Be 55 years of age or older
- Certified by the State to require nursing facility level of care
- Able to live safely in the community at the time of enrollment, and
- Reside in the service area of the Program of All-Inclusive Care for the Elderly organization. Currently, Program of All-Inclusive Care for the Elderly is only available in New Hanover and Brunswick counties through the Elderhaus, Inc. Program of All-

Inclusive Care for the Elderly Program (began operating February 1, 2008). Additionally, Program of All-Inclusive Care for the Elderly sites are being developed in Fayetteville, North Carolina (projected start date of 2009) and Burlington, North Carolina (projected start of September 1, 2008).

Services provided by the Program of All-Inclusive Care for the Elderly include, but are not limited to:

- All Medicaid-covered services, as specified in the State's approved Medicaid plan
- Multidisciplinary assessment and treatment planning
- Social work services
- Skilled nursing care
- Primary care physician services
- Medical specialty services
- Specialized therapies
- Recreational therapy
- Personal care services
- Nutrition counseling
- Meals
- Medical Supplies
- Home Mobility Aides
- Transportation
- Prescriptions
- Laboratory tests, X-rays, and other diagnostic procedures
- Prosthetics, orthotics, durable medical equipment and corrective vision devices

### ***Transition Services***

One-time set-up transition expenses for individuals who are transitioning from a nursing facility, a state-operated developmental center or private Intermediate Care Facility-Mental Retardation group home, or a state-operated psychiatric hospital to a community setting or another living arrangement where the person is directly responsible for his/her own living expenses include the following:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, bed/bath linens;
- Set-up fees or deposits for utility or service access including telephone, electricity, heating and water; and
- Service necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. Transition services do not include monthly rental or mortgage expenses; regular utility charges; and/or household appliance or diversion/recreational items such as televisions, VCRs, and DVDs. These services will be

provided only once and may not be accessed for any subsequent moves within or into the community.

### ***State Plan Services***

In addition to the waiver program services, all Money Follows the Person participants will be eligible for Medicaid State Plan Services.

### ***Supplemental Demonstration Services***

Under the demonstration grant, the supplemental services will be provided and reimbursed with demonstration funds when not covered under current CAP waiver services and benefits. These services are not long term in nature, but may be essential for successful transition to the community. Units and rates will be set as the CAP waiver renewals are being revised. Some are currently established (but rates may change). Some services will be dependent on the needs of the individuals and therefore a set rate would not be applicable.

- Assistive technology (ex., computer)
- Durable medical equipment
- Nutrition services
- Substance Abuse
- Housing
  - Furnishings
  - Security deposits
  - Utility set-up fees
  - Adaptive equipment/assistive technology to facilitate sustained community living
  - Home modifications and retrofitting
- Service animals
- Transportation—one time solutions
- Family support services (such as training the crucial informal support network on services available)
- Private duty nursing
- Health and safety assurance
- Independent Living Skills
- Vehicle Modifications (for CAP/DA)
- Tele-health monitoring equipment
- Products for the maintenance of health and hygiene

### **Transition at termination**

The 1915(c) waivers and the Medicaid State Plan Services will continue to provide services at the termination of the Money Follows the Person project. Program participants will also be assisted to access other community-based services for which they may qualify. At the end of demonstration services, CAP waiver services and benefits for which an individual qualifies will support continued community and home based living. This will result in no loss of services and supports to individuals who transitioned under demonstration services.

## Consumer Supports

### Educational Materials

Division of Medical Assistance will develop informational brochures that outline the services provided through Money Follows the Person. Current consumer information will be updated to include information about the Money Follows the Person Demonstration Grant project.

### Back-up Systems

**CARE-LINE.** The North Carolina Department of Health and Human Services toll-free information and referral telephone service, CARE-LINE [1-800-662-7030; local calls: 855-4400 or 919-733-4851 (TTY)], is available to provide information and referrals regarding human services in government and non-profit agencies. A database of over 10,000 agencies across North Carolina is available to staff who are assisting callers. The CARE-LINE is available 24 hours, 7 days a week, effective March 27, 2008. Consumers, their families/guardians, and other customers have a service to call which provides information and referrals on a wide array of human services any time of the day or night.

**NCcareLink.** North Carolina maintains a comprehensive health and human services web site called NCcareLINK (<http://www.nccarelink.org>). It is a collaborative effort of the North Carolina Department of Health and Human Services and many other government and non-profit information and referral stakeholders across North Carolina. This web site provides up-to-date information about programs and services across North Carolina for families/guardians, seniors, youths and everyone in-between (see Attachment F).

NCcareLink system:

- Provides current consumers with local resources
- Introduces potential consumers to local resources
- Outlines services for persons moving to North Carolina
- Provides a marketing opportunity for local providers
- Helps Local Management Entity staff make appropriate referrals to provider agencies.

NCcareLink has been designed with the end-user in mind. Partnering agencies—through a Memorandum of Understanding with the Office of Citizen Services—provide six month updates to the system on all of the Providers in their region. Partnering agencies are:

- non-profit entities that offer health and human service programs
- Government agencies (local/state/deferral)
- Self-help/support groups
- Faith-based organizations that offer specific health and human services program(s) to the community
- Civic/social groups that offer specific health and human services programs(s) to the community
- For-profit agencies that offer a sliding scale payment plan or accept governmental funds or offer unique services that meet health and human services needs at the community level
- An organization must be in business providing specific service(s) for a minimum of six consecutive months, have an established physical address and contact telephone number, and have a license to provide services.

Individuals may also access 911, the statewide suicide hotline at 1-800-273-8255, and/or visit the emergency room at a local hospital.

**Personal Emergency Response System (PERS).** Personal Emergency Response System is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals from the company ADT Security Services. Personal Emergency Response System services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

The Personal Emergency Response System may be helpful in the following situations:

- A fall has occurred and the individual cannot get up on their own. The attendant on the other end of the response system would obtain the information regarding the emergency and respond according to the nature of the emergency.
- A personal care attendant does not show up. The individual would make a call using the Personal Emergency Response System and appropriate action would be taken.

### **Consumer Complaints**

The Department of Health and Human Services Ombudsman Program was created to address inquiries and complaints that consumers and their legal/guardians have regarding services that Department of Health and Human Services oversees or administers. Through this service, Office of Citizen Services staff serves as the central point of contact for the Department of Health and Human Services Secretary's Office, Governor's Office, other elected and appointed officials, department personnel, all government agencies, non-profit and private agencies, advocates and residents of the state.

Constituents who contact their governmental representatives or any human service professional with complaints concerning Department of Health and Human Services or who are in need of human service programs are referred to the Department of Health and Human Services Ombudsman Program. When a complaint is received, Office of Citizen Services staff serves as a liaison between the resident and the Department of Health and Human Services program specialist. Office of Citizen Services staff ensures that complaints are thoroughly examined and investigated. Staff determines the most appropriate parties to contact and work with to resolve the situation. Feedback is provided to elected officials regarding their constituents' concerns. Ensuring that consumers have the proper channel for addressing their concerns is the key to this program. If a person's complaint is valid, steps are taken to rectify the situation. If the complaint is not valid, time is spent with the resident to educate him/her on the process and help the person understand why the situation was handled in a certain manner. In addition, staff relies on an extensive statewide database to give additional referrals that may be of assistance.

The Regional Long Term Care Ombudsmen program can also be accessed through the CARE-LINE and is available Monday through Friday, except state holidays, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

## Self-Direction

Self direction is an *option* currently afforded to individuals under CAP/Choice waiver program. CAP/Choice is a program of participant-directed care those who are elderly and/or have a disability, and/or their family/guardian, who wish to remain at home and have increased control over their services and supports. CAP/Choice reflects North Carolina's health reform policy objectives of promoting consumer choice and decision-making, reducing health-care costs, and identifying key stakeholders, especially consumers in its approach to reform the delivery of services.

North Carolina's Division of Medical Assistance is committed to expanding the CAP/Choice program statewide. The services under CAP/Choice are currently offered in four North Carolina counties: Cabarrus, Duplin, Forsyth, and Surry. The waiver was approved March 31, 2008 with a retroactive date for services of January 1, 2008. A systematic roll-out to all of North Carolina's remaining counties will begin January 1, 2009. CAP/Choice services will become an option under the traditional CAP/DA waiver program, which is already implemented statewide. Training specific to CAP/Choice will be provided to the CAP/DA lead agencies not already providing CAP/Choice services.

North Carolina's Money Follows the Person Demonstration Grant project includes the same services as the CAP/Choice waiver with regard to compliance with the Freedom of Choice requirement. Participants and/or their family/guardian may choose any willing and qualified provider; receive information about providers; select whom to interview; and meet, interview and select the provider of their choice.

Under CAP/Choice, participants will be able to:

- Choose (hire) the Personal Assistant who will provide their care support
- Train, supervise and evaluate the worker
- Negotiate the rate of pay and other benefits
- Terminate the worker should this become necessary
- Select individual providers and direct reimbursement for specified waiver services
- Engage in a cooperative working arrangement with a financial manager (FM) who will pay the participant's worker, handle federal/state taxes and other payroll/benefit functions related to the employment of the worker, and reimburse service providers under the direction of the participant.

Self-Direction Support Provisions: Self-Directed Services is an option afforded the individual (or in the case of children, their parents or other legally responsible relatives) and others that the individual asks to assist him/her to direct some or all of the services and supports in their person-centered plan Self-directed means that the individual or the family (in the case of minors) hires and directs the provider of services and directly authorizes the financial management services provider to make payment on the participant's behalf for a goods or service included in the person-centered plan.

Care advisors will inform individuals and/or families/guardians of the option to direct services and supports during the assessment and person-centered planning process. Each plan of care will

include a risk assessment and identify appropriate risk management strategies. The individual who desires to direct his/her services will be assessed to determine if the individual is able to independently direct services. If the individual has a court appointed guardian, is a minor, or is assessed as needing assistance to direct services, a representative will be required for the individual to participate in Self-Directed Supports Option. The representative may be a family member, friend, legal guardian, other legally appointed representative, or income payee. A person who provides services to the individual may not be the representative. This includes any employee of a licensed facility where the individual lives or any member of an Alternative Family Living or foster home where the individual resides. The representative must:

- Demonstrate knowledge and understanding of the individual's needs and preferences
- Agree to a predetermined level of contact with the individual
- Be willing and able to comply with program requirements
- Be at least 18 years of age
- Be approved by the individual and/or his/her legal representative to act in this capacity.

Care advisors will be responsible for identifying the need for a representative for the individual and assuring that the representative meets established criteria.

Individuals who are considering the Self-Directed Supports Option will be provided educational opportunities and materials. They will have further educational opportunities through individual training and education services. The individual and/or their guardian, in conjunction with the planning team, will assess the need for Supports Brokerage and the specific activities to be performed for CAP/MR-DD participants. Care advisors will also be responsible for ensuring that the person-centered plan identifies how emergency back-up services will be furnished for workers employed by the individual and/or their guardian. As an added safeguard, provision may be made via on-call service agreements with licensed home health agencies to provide staff in the event that emergency back-up strategies, identified in the person-centered plan, cannot be implemented and there is the potential that the person's health and welfare would be jeopardized. The individual's care advisor will authorize the provision of these on-call emergency back-up services.

The CAP/MR-DD renewal waiver will include an offering of self-direction to those in need of low-intensity supports to the extent available. The waiver is currently being written by Division of Mental Health, Developmental Disabilities, and Substance Abuse Services staff for submission to CMS early summer 2008. The proposal will include details for self-direction options under this waiver.

See Attachment G for further details regarding self-direction as an option for individuals under CAP/Choice services.

## Quality

### **Quality Assurance for Integrating Services into New or Existing 1915(c) Waivers**

#### ***Aging Individuals with Care Needs and/or Disabilities Residing in a Nursing Facility***

North Carolina intends to integrate the Money Follows the Person Demonstration Grant services into an existing 1915(c) waiver for individuals who require the level of care provided by a nursing facility transitioning to the community. The same level of quality that applies to the CAP/DA waiver will apply to those individuals during the transition and during the demonstration.

#### ***Individuals Who Are Residing in Private Intermediate Care Facility-Mental Retardation Facilities or State-operated Intermediate Care–Mental Retardation Facilities (Developmental Centers)***

North Carolina intends to integrate the Money Follows the Person Demonstration Grant services into an existing 1915(c) waiver for individuals with developmental disabilities transitioning from a state-operated developmental center or private Intermediate Care Facility-MR facilities. The same level of quality that applies to the CAP/MR-DD waiver will apply to those individuals during the transition and during the demonstration.

### **Quality Assurance for State Plan Services**

Only 1915(c) waivers will be utilized.

### **Waiver Assurances**

#### ***CAP/Choice***

Attachment H provides information from Appendix H of the CAP/Choice Waiver Application Amendment.

#### ***CAP/DA***

CAP/DA is currently in the renewal process with an anticipated submission date of September 2008. The current Waiver Quality Management Plan is attached (Attachment H1).

#### ***CAP/MR-DD***

North Carolina's Quality Management plan for the current 1915(c) Home and Community Based Waiver for individuals with developmental disabilities can be found in Attachment section ("Quality Management Plan—1915(c) Waiver"). This plan reflects processes for assuring that the Money Follows the Person Demonstration Grant project will reflect the same level of quality assurance and improvement activities required under Appendix H of the Home and Community Based Waiver application for those individuals transitioned to the community into a home and community based services waiver during the demonstration.

## **Level of Care Determinations**

### ***CAP/DA and CAP/Choice***

Local lead agencies are responsible for coordinating with case managers in the assessment of the individual's strengths and needs in six basic areas of functioning<sup>4</sup> to determine individuals who are potentially eligible for waiver services, assuming funding availability and that the individual meets the nursing facility level of care.

A continued need review is completed annually for all participants. The statewide utilization review vendor reviews continued need reviews including the long term care level form (FL-2) reflecting the nursing facility level of care.

The instruments and process for determining level of care are the same as those described in the approved waiver. Nursing facility level of care criteria is applied to determine eligibility for the waiver. Documentation of nursing facility level of care is provided using the long term care level form (FL-2).

### ***CAP/MR-DD***

Local Management Entity's are required through Performance Measures in the Local Management Entity Performance Contract to provide a system of screening, triage and referral to services in a prompt, user-friendly manner. This includes individuals who are potentially eligible for waiver services, assuming funding availability and that the individual meets the Intermediate Care Facility–Mental Retardation level of care. Individuals referred for waiver funding have their level of care assessed by a psychologist or physician. Clinical staff employed by Division of Mental Health – Developmental Disabilities/Substance Abuse Services makes the final determination of level of care.

A continued need review is completed annually for all participants by a Qualified Professional in the field of developmental disabilities. The Local Management Entity is responsible for signing the mental health services level form (MR-2) reflecting Intermediate Care Facility-Mental Retardation level of care at the annual continued need review.

Clinical staff employed by Division of Mental Health – Developmental Disabilities/Substance Abuse Services through the Murdoch Developmental Center maintains a spreadsheet to record timeliness of level of care reviews. Division of Medical Assistance staff audit a random sample of 15 records monthly, which includes a review of the level of care determination.

### ***Program of All-Inclusive Care for the Elderly (PACE)***

Prior to enrollment in Program of All-Inclusive Care for the Elderly, Medicaid must certify the applicant meets the state's nursing facility level of care criteria. Annually, the Program of All-Inclusive Care for the Elderly organization must submit the Long-Term Care Uniform Screening Tool to verify that the enrollee continues to meet nursing facility level of care requirements.

## **Plan of Care/Person-Centered Plan Development**

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<sup>4</sup> Self care, receptive and expressive language, learning, mobility, self-direction (independent control over one's social and individual activities), and capacity for independent living (maintaining a full and varied life in one's own home)

### ***CAP/DA and CAP/Choice***

Case managers employed by individual provider agencies are responsible for developing each person-centered plan to address the services that are needed to maintain the individual's health, safety, functions, and independence.

Case managers revise the plan as needed. Division of Medical Assistance contracts with a statewide vendor to monitor plans to assure that:

- participants continue to meet the criteria for nursing facility level of care;
- re-evaluations are conducted annually;
- participants are provided with the option for institutional care; and
- services are delivered as approved.

Twenty-four hour back up will be implemented according to the plan of care/person centered plan as appropriate. Each participant who requires 24 hour backup will have a detailed, written plan describing what is needed, persons responsible, what to do in an emergency, and any other details needed for successful community living. Case managers are responsible for ensuring 24 hour care/back up is carried out.

### ***CAP/MR-DD***

Case managers employed by individual provider agencies through a contract with the Local Management Entity develop an individual person-centered plan for each applicant/participant and 100% of these plans are submitted for review and approval through a statewide utilization review vendor.

Case managers revise Plans of Care as needed. Revised plans must be approved by the statewide utilization review vendor.

Case managers monitor Plans of Care to determine whether services are delivered as approved. Local Management Entities monitor service provision through review of paid claims data reflecting the amount and frequency of services billed for specific consumers on an as-needed-basis, as well as through post-payment reviews. The State audits a random sample of 15 records monthly through Division of Medical Assistance's Behavioral Health Unit, Quality Assurance Reviews, which includes a review of encounter data/paid claims. In addition, Department of Health and Human Services/Developmental Disabilities/Substance Abuse Services Program Accountability Team and Division of Medical Assistance's Behavioral Health Unit conducts a Medicaid Compliance Audit that includes waiver services

Case managers monitor appropriateness of service delivery in light of any changes in the consumer's needs. Monthly face-to-face monitoring is required. Local Management Entities have responsibility through the Performance Contract with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to produce reports and use for planning and improvement. These include provider trends such as assessment of provider quality, results of audits and monitoring activities, technical assistance, and trainings. The reports analyze and summarize patterns and trends related to providers. All initial person-centered plans, revisions to the person-centered plans, and care of need reviews are reviewed and approved by a statewide utilization review vendor.

Twenty-four hour back up will be implemented according to the plan of care/person centered plan as appropriate. Each participant who requires 24 hour backup will have a detailed, written plan describing what is needed, persons responsible, what to do in an emergency, and any other details needed for successful community living. Case managers are responsible for ensuring 24 hour care/back up is carried out.

***Identification of Qualified Home and Community Based Services Providers for those Participants Being Transitioned  
CAP/DA and CAP/Choice***

Participants are offered choices of waivers versus institutional care and between/among providers. Choice must be documented in the person-centered plan. The local lead agencies are responsible for verifying that providers within their catchment areas meet all the requirements to provide CAP/DA services. The Division of Medical Assistance Provider Enrollment Unit is responsible for enrolling all CAP/DA providers based on meeting endorsement criteria.

***Program of All-Inclusive Care for the Elderly (PACE)***

Each Program of All-Inclusive Care for the Elderly site develops their own Quality Assurance Performance Improvement Plan as part of the Program of All-Inclusive Care for the Elderly application to CMS. This is only representative of Elderhaus Program of All-Inclusive Care for the Elderly, not the other sites in development, though those will have similar content to receive approval from CMS. Elderhaus is currently the only active site program.

The goal of the Elderhaus Program of All-Inclusive Care for the Elderly Quality Assurance Performance Improvement Plan program is to provide high quality, sustainable services. The improvement process considers the institutional context, describes desired performance, identifies gaps between desired and actual performance, identifies root causes, selects interventions to close the gaps and measures changes in performance.

Specific objectives of the Elderhaus Program of All-Inclusive Care for the Elderly Quality Assurance Performance Improvement Plan are to:

- Assure effective, timely and safe delivery of care
- Identify core and critical processes that most affect participant outcomes as a focus of process standardization and performance improvement.
- Ensure all team members, staff, and contract providers are involved in the development and implementation of the quality assessment and performance improvement activities and are aware of the results of these activities.

The full Quality Assessment Performance Improvement Plan can be found in Attachment I.

***CAP/MR-DD***

Participants are offered choices of waivers versus institutional care and between/among providers. Choice must be documented in the person-centered plan.

The Local Management Entity is responsible for verifying that providers within its catchment area meet all the requirements to provide CAP/MR-DD services through the endorsement process. The Local Management Entity is responsible for performing provider endorsement

activities in accordance with the policies, processes, and timeframes outlined in the Department of Health and Human Services Provider Endorsement policy. The Division of Health Service Regulation is responsible for licensure of all healthcare facilities in which CAP/MR-DD waiver recipients may reside. The Division of Medical Assistance Provider Enrollment Unit is responsible for enrolling all CAP/MR-DD providers based on meeting endorsement criteria.

Local Management Entities maintain responsibility through the Performance Contract with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to provide ongoing monitoring of providers within their catchment areas. In addition, if through the monitoring process it is determined that the provider no longer meets the requirements of endorsement to provide a specific CAP/MR-DD service, the Local Management Entity may withdraw endorsement resulting in withdrawal of to provide and bill for the specific service. The State provides monitoring of providers as well through annual Division of Mental Health/Developmental Disabilities/Substance Abuse Services and Division of Medical Assistance Medicaid Compliance Audits. Division of Mental Health/Developmental Disabilities/Substance Abuse Services has in place a protocol for summary suspension and revocation of authorization to receive public funding for providing MH/DD/SAS services.

Enrolled providers are required to ensure that all direct care staff receive required training as outlined in Appendix B-2 of the CAP/MR-DD waiver, Provider Qualifications. Local Management Entities maintain responsibility through the Performance Contract with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to provide ongoing monitoring of providers within their catchment area. Local Management Entities have responsibility through the Performance Contract with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to produce reports and use for planning and improvement. These include provider trends such as assessment of provider quality, results of audits and monitoring activities, technical assistance, and trainings. The reports analyze and summarize patterns and trends related to providers. The state provides monitoring of providers as well through annual Division of Mental Health/Developmental Disabilities/Substance Abuse Services and Division of Medical Assistance Medicaid Compliance Audits.

### **Health and Welfare**

#### ***CAP/DA and CAP/Choice***

Case managers maintain responsibility for monitoring each waiver participant's changing needs, situation or condition. The case manager monitors the services to the participant through direct observation, including a monthly contact, participant report, and review of provider documentation. Case managers are responsible for reporting any need for protective services due to suspected abuse, neglect, or exploitation to the county Department of Social Services as well as the provider agency.

#### ***CAP/MR-DD***

Case managers maintain responsibility for monitoring waiver participant's changing needs, situation or condition, including a monthly face-to-face visit. Case managers are responsible for reporting any need for protective services based on requirements in state legislation to the county Department of Social Services as well as the provider agency. The North Carolina

Administrative Code requires all Local Management Entities and provider agencies to participate in a Division of Mental Health/Developmental Disabilities/Substance Abuse Services-coordinated system for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and consumer behavior issues. In addition, per administrative rule, each area board for MH/DD/SAS services is required to operate at least one Client Rights Committee, and require contracted providers to operate a Client Rights Committee as well. Local mortality reviews are conducted by the Quality Improvement Committee of the Local Management Entity. The Community Services Customer Rights Team tracks and analyzes all complaints that come to the Division. Data collected on complaints include complainant and consumer information, the type of complaint, results of attempts to resolve the complaint, and the number of contacts.

A tool is being developed (draft form) to identify risk issues within the population serviced by CAP/MR-DD. It is foreseen that this tool (Attachment H) will be a means of honest communication between team members including the individual. It is not to be done in isolation but as a way to identify risks in all areas. From the risks identified, everyone involved in the consumers circle would have ways of looking at decreasing risks by education/training, natural supports, or environment.

***Program of All-Inclusive Care for the Elderly (PACE)***

The Program of All-Inclusive Care for the Elderly must also conduct a comprehensive health and safety assessment to ensure that the applicant's health, safety, or welfare will not be jeopardized by living in the community. The assessment must include

- a. An on-site evaluation of the applicant's residence
- b. An evaluation of the applicant's social support system, including the willingness and capabilities of all informal caregivers
- c. An evaluation of whether the applicant can be safely transported to the Program of All-Inclusive Care for the Elderly center

**Administrative Authority for the Waiver**

***CAP/DA and CAP/Choice***

Division of Medical Assistance is responsible for monitoring program administration for the CAP/DA waiver. Division of Medical Assistance provides information and guidance to counties that have CAP/DA programs and conducts annual on-site visits to review program operations and the provision of technical assistance to facilitate management of the program.

***CAP/MR-DD***

Division of Mental Health/Developmental Disabilities/Substance Abuse Services and Division of Medical Assistance are responsible for monitoring program administration. Division of Mental Health/Developmental Disabilities/Substance Abuse Services is the lead agency for statewide operations of the CAP/MR-DD waiver and Division of Medical Assistance oversees the overall operation of the waiver according to federal and state guidelines. These divisions cooperate in the operation of the waiver under a Memorandum of Understanding that delineates each division's responsibilities.

## **Housing**

The lack of affordable and accessible housing in North Carolina remains a significant barrier to meeting the needs of extremely low income households, the elderly, and persons with disabilities, in their communities. However, North Carolina has made significant, if limited, progress in this area over the past five years. In May of 2002, the Secretary of the Department of Health and Human Services established the position of Housing Coordinator within this office. The Department of Health and Human Services Housing Work Group (HWG), with representatives of all Department of Health and Human Services service divisions, was formed to implement the broad agenda for this new initiative: reducing fragmentation of housing efforts within the Department; increasing the housing capacity of the State and local agencies to maximize existing housing resources; and more effectively engaging the affordable housing industry to expand supportive housing opportunities for Department of Health and Human Services constituents.

### **Ensuring Sufficient Qualified Residences**

As a result of this department-level commitment, the North Carolina Housing Finance Agency has partnered with the Department of Health and Human Services since 2002 to facilitate the inclusion of persons with disabilities within Low Income Housing Tax Credit (Housing Credit) properties. All Housing Credit properties funded in North Carolina since 2004 must develop a Targeting Plan that makes 10% of the units available to extremely low income persons with disabilities, including those who are homeless. To date, over 1,175 units of quality, affordable rental housing have been funded. The Key Program, an operating assistance program created by the North Carolina Housing Finance Agency and the Department of Health and Human Services, is also available to Housing Credit properties funded since 2004 to ensure that targeted units are affordable to persons with incomes as low as Supplemental Security Income (SSI). Since 2006, 5% of units in all new Housing Credit properties must meet a higher than legally mandated level of accessibility, including curbless showers and full-turn-around bathrooms.

In 2004, the Department's Housing Work Group prepared a successful grant application to CMS for a Real Choice Systems Change Grant: Integrating Long-Term Supports with Affordable Housing. The grant, a partnership between the Department of Health and Human Services and the North Carolina Housing Finance Agency, was designed to bring technical assistance to local communities to expand the collective capacity of the human service system to implement the Housing Credit targeting partnership and promote the expansion of affordable community housing opportunities integrated with long-term supports.

The Department of Health and Human Services is seeing additional tangible results from collective, cross-disability housing advocacy. The 2006 and 2007 legislative budgets included substantial increases in funding to expand the Housing 400 Initiative, the Department of Health and Human Services–Housing Finance Agency partnership in addressing the housing needs of extremely low income persons with disabilities. In total, \$18.4 million of capital funding to the North Carolina Housing Trust Fund and \$5.2 million of recurring funds for the Key Program have been appropriated to expand production of a range of independent and supportive housing units targeted to persons with disabilities and incomes as low as SSI.

While these are housing resources that were not available five years ago, the continually shrinking supply of federally subsidized housing resources means that Money Follows the Person participants will be challenged to locate safe, decent, accessible, and affordable housing in communities of their choice. Participants will, however, be able to avail themselves of significant improvements developed as part of the Real Choice Grant in the available tools and capacity of supportive service providers to assist them in finding and accessing housing resources.

These tools include county-specific listings of affordable housing resources for each of North Carolina's 100 counties and an Affordable Housing Primer that gives basic information about navigating the affordable housing system, including North Carolina-specific contact information for housing programs across the state. These tools are now posted and updated on the website of the North Carolina Housing Coalition. North Carolina has also implemented an online housing search tool, [www.NCHousingSearch.org](http://www.NCHousingSearch.org), which is currently operational and marketing to landlords. Searchable by a number of criteria (location, proximity of transportation, accessibility, etc.), this service is designed to provide real-time information, posted by participating landlords, of units available for rent across the state. A statewide inventory of affordable housing resources is in the development stage.

Service providers working with Money Follows the Person participants will be invited to join one of 30 Housing Support Committees organized across the state. Access to the Housing Credit and Housing 400 Initiative units is managed at the local level by the Housing Support Committee, a collaborative of human service providers who have come together to make referrals to these new housing opportunities and ensure that tenants have access to the ongoing supportive services they may need to live successfully in the community. As each new property is funded, a Local Lead Agency (LLA) is identified who will represent the local Housing Support Committee in dealing with property management. Members of the Housing Support Committee make referrals to the property owner and the Local Lead Agency maintains a waiting list, in the event of turnover, once the specified number of targeted units is occupied. The Housing Support Committee members are also knowledgeable about other affordable resources, as well as the range of community services and providers available in their community.

North Carolina has 131 public housing agencies (PHAs) or Housing Choice Voucher administering agents. The availability and quality of public housing units varies across locations. The availability of Housing Choice Vouchers is more limited, with many locations having closed waiting lists or waits up to two and three years. Over the past few years, most, if not all, public housing agencies have been approached by the disability community, through the Housing Support Committee or other efforts, about re-establishing a preference for persons with disabilities. While this has been successful in some areas, in others it has not, where public housing agencies are responding to pressure on their budgets to direct assistance to higher income levels. Efforts to engage public housing agencies for the benefit of the Money Follows the Person target populations will continue.

Access to other qualified residences—community-based settings housing no more than four individuals—will likely require providers who are willing to re-tool existing residential settings licensed under North Carolina facility rules. Supervised Living settings are licensed under

Mental Health, Developmental Disabilities and Substance Abuse rules; Family Care Homes are smaller board-and-care facilities. Both may serve as few as two individuals, but the majority of these settings are currently serving the maximum number allowed by the rules (six persons in Supervised Living and seven in Family Care).

**Qualified Residences**

Refer to **Attachment K** for a list of defined qualified residences.

## **Continuity of Care Post Demonstration**

The State's efforts to rebalance long-term care support programs and meet demonstration objectives include continuity of care post demonstration. The demonstration project will include people transitioning into all North Carolina Home and Community Based Services programs: CAP/DA, CAP/MR-DD, CAP/Choice, and Program of All-Inclusive Care for the Elderly. Each program area has estimated its capacity to accept an increased number of applicants through this project, with the assumption that each new program participant will continue to be served after the end of the first year of community based service provision.

Below are descriptions of the qualified home and community-based options that will be available to individuals following the year they receive transition services. Money Follows the Person demonstration participants have priority and will be able to bi-pass waiting lists to enter into any of the below listed programs if they meet the specific waiver qualifications.

### *CAP/DA and CAP/Choice*

These waivers serve elderly and disabled individuals who meet the same level of care that is needed to enter a nursing facility but who wish to remain home. The waivers offer a service package that includes fifteen services designed to assist consumers meet their long-term care needs at home. Consumers can choose from several service delivery options, ranging from all agency-based services to various levels of self-direction and opportunities to manage their own care.

### *CAP/MR-DD*

The CAP/MR-DD Program is designed to give persons eighteen years and older with mental retardation and developmental disabilities a cost-effective alternative to care in an intermediate care facility for persons with mental retardation. The goal of CAP/MR-DD is to allow individuals to return to and live in their community with as much independence as possible.

### *Program of All-Inclusive Care for the Elderly*

Palmetto Senior Care is a PACE program that provides comprehensive care that allows frail elderly consumers to live within their communities. This program serves persons 55 years of age and older and provides all Medicare and Medicaid covered services, as well as any other items or medical, social or rehabilitative services an interdisciplinary team determines are needed. At this time, there is one Program of All-Inclusive Care for the Elderly in New Hanover and Brunswick counties through the Elderhaus, Inc. Additionally, sites are being developed in Fayetteville, North Carolina (projected start date of 2009) and Burlington, North Carolina (projected start of September 1, 2008).

For those participants who do not meet waiver qualifications, a transition service plan will be developed and assistance with referrals to supportive programs will be provided. Referrals may include connecting participants to local Councils on Aging and/or Departments on Aging, which coordinates aging services that provide transportation, personal care, chore services, adult day care, information and referral, outreach, and case management. For people with physical disabilities, a referral to the regional Center for Independent Living for assistance

with services as well as a referral to the Department of Social Services for assessment of appropriate services will be made.

Referrals will also be made to regional Aging and Disability Resource Connections. The Aging and Disability Resource Connections are an important community resource that can provide support to Money Follows the Person participants who are elderly and/or with disabilities regarding such services as insurance counseling, information referral and assistance, emergency rent assistance, and caregiver support. Aging and Disability Resource Connections staff will also assist consumers with evaluating all services for which they may qualify and provide assistance with applying for those services.

## **Organization and Administration**

### **Organizational Structure**

The North Carolina Money Follows the Person demonstration grant will be managed by the Department of Health and Human Services. This structure will provide great coordination of services across programs as well as high-level support within the Department of Health and Human Services. The Division of Medical Assistance will have oversight responsibilities for the grant.

**Attachment E** is an organizational chart for the Money Follows the Person demonstration grant.

### **Staffing Plan**

Project staff for the North Carolina Money Follows the Person demonstration grant will include

- a. Project Director  
A Project Director, hired to provide direct management of the project, started in the position on February 28, 2008. The project director will be responsible for the project management, policy development, outreach development, budget management, supervision of project staff, and training and program analysis.
- b. Program Specialist  
The program specialist has not been hired. The person will manage the project plan and assist with project management including assisting in day-to-day program operations; serving as the liaison to the transition coordinators; and coordinating education, outreach, and training activities.

### **Billing and Reimbursement Procedures**

The Medicaid Program's fiscal agent, Electronic Data Systems Corporation, is responsible for ensuring that CAP/DA, CAP/Choice, and CAP/MR-DD claims are paid correctly through a contract with the Division of Medical Assistance. Electronic Data Systems Corporation has established edits and audits in the claims payment system to ensure that payment is made in accordance with the approved methodology.

The Program Integrity section in the Division of Medical Assistance conducts reviews to identify provider agencies who appear to be abusing or defrauding Medicaid, identifies and collects provider and recipient overpayments, educates providers and recipients when errors or abuse is detected, ensures that recipients' rights are protected, and identifies needs for policy and procedure definitions or clarifications.

Post-payment reviews by the Division of Medical Assistance look at the complete audit trail: the approval of the person-centered plan, the case manager's authorization to the provider to render approved services, service provision, service documentation, and the case manager's authorization for claims submission and actual claims data.

CAP/Choice participant files are monitored as submitted and/or changed by the Division of Medical Assistance quality assurance contractor, The Carolinas Center for Medical Excellence. Quality assurance reviews determine that participants are classified correctly at either the

intermediate-care or skilled-nursing level of nursing facility care. Results of monthly monitoring are reviewed by Division of Medical Assistance CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/Choice is operated. The quality assurance review process is not a negative process, but one that leads to the strengthening of program. Additionally, The Carolinas Center for Medical Excellence looks at claims data for possible inappropriate payment of services and monthly budget monitoring.

The Resource/Regulatory Team of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services also develops a monthly report that describes the services paid for waiver recipients, the number of units billed, the cost, and the number of consumers receiving each service. These data provide the ability to view services paid per individual consumer, as well as per individual Local Management Entity or provider, and may be used in the event that there is a concern or complaint received regarding a specific consumer or provider. The Division of Mental Health/Developmental Disabilities/Substance Abuse Services Accountability Team and the Division of Medical Assistance Behavioral Health Unit routinely conduct a Medicaid Compliance Audit that includes the waiver services. Auditors review Medicaid-billed events for a sample of individual directly enrolled providers. This review includes monitoring of both Division of Medical Assistance/Waiver and Division of Mental Health/Developmental Disabilities/Substance Abuse Services requirements that address staff qualifications, service authorizations, service plans, service documentation, and billing protocols. These reviews ensure that documentation and other requirements are followed for services providers bill to Medicaid and for which they are paid.

## **Evaluation**

Evaluation is not a required component of the Money Follows the Person Operational Protocol. Although states may propose to evaluate unique design elements from their proposed Money Follows the Person programs, the state of North Carolina has opted not to include its own evaluation. The State will utilize data collected by the national evaluator (Mathematica, Inc.) for the Money Follows the Person evaluation as indicators of the project's effectiveness.

## **Final Project Budget**

### **Budget Presentation and Narrative**

North Carolina's budget projections for this grant are based on the anticipated enrollment of 552 individuals for the 2007-2011 project period. The State utilized existing data and experience gained from its earlier nursing home transition grant and from its Case Management System to estimate the number of individuals that would likely be eligible under the terms of the grant. The State based its cost allocations on the uniform transition of the 552 individuals over each month of the implementation grant.

#### Medicaid Administrative Costs

The State has hired a full time Grant Project Director who is responsible for grant's operations. The State projects hiring a Project Program Specialist with a base salary of approximately \$57,979 and the Administrative Assistant with a base salary of approximately \$26,825. The two salaries include related fringe benefits of 33% for each position. In addition, the State is projecting ancillary expenditures including travel, equipment, supplies, brochures, and postage to be approximately \$60,000 over the life of the grant. The State projects the total administrative expenditures to be approximately \$889,359 over the life of the grant.

#### Qualified Home and Community-Based Services

The State also projected the 552 individuals would need to utilize more qualified Home and Community-based services due to these individuals having previously resided in a qualified nursing facility for at least a six-month period. It has been the States experience that one of the larger impediments to transitioning to the community has been a lack of community support. In response to this the state has budgeted for a larger percentage of services being utilized.

#### Home and Community-based Demonstration Services

The State is up-dating all CAP waivers to incorporate the new demonstration services that will be used to support individuals in their efforts to access services in the community. These services are mandated to be imposed no later than March 2010. The CAP/MR-DD services will be bundled, which are projected to be utilized by more than 50% of the Money Follows the Person target population, and will address an important gap in the State's long term system. Based on previous experience with the nursing home transition grant it is the State's experience that this service will be a resource for community services and assist with education and training of the individual community supports for those choosing to transition from the institutional setting.

#### Supplemental Demonstration Services

The state is projecting that a less than 10% of the individuals to be served through the Money Follows the Person grant will utilize the State's supplemental demonstration service of adaptive devices. From pervious experience the State has determined a need for adaptive devices including lift chairs, automatic door openers and other electronic assertive devices.

### **Money Follows the Person Budget Forms**

See Attachments N, N1, N2.

**Attachment A**

**Medicaid Uniform Screening Tool (MUST) form**

## Attachment B

### Community Options Interest Survey: CAP/MR-DD

Guardian: \_\_\_\_\_ Resident: \_\_\_\_\_

Surveyor: \_\_\_\_\_ Date of Survey: \_\_\_\_\_

Hello. My name is \_\_\_\_\_ and I am a \_\_\_\_\_ at the \_\_\_\_\_ Center. We are calling all of the residents [**or the legal guardians**] to gather information for the Center for planning purposes. It will only take a few minutes to complete the survey. Is this a convenient time for you or would it be better to arrange another time to call back?

[If yes, proceed with survey. If no, schedule a date and time to call again.]

The \_\_\_\_\_ Center is committed to exploring opportunities for individuals to live in community homes with the supports they need to be safe, happy, and healthy. We want input from you as a resident [**or as \_\_\_\_\_'s legal guardian**] on your interest in community living.

If there were an option for you [**or for the individual in your guardianship**] to relocate to a community living arrangement, what circumstances or conditions would you [**or for the individual in your guardianship**] need to consider before making a decision to live in the community?

a. **The location of the community arrangement**

Community located close to family	___Yes ___No
A particular region in the state	_____
A particular county in the state	_____

b. **The type of living arrangement**

Home owned or leased by you or a family member	___Yes ___No
Apartment leased by you or a family member	___Yes ___No
Public housing	___Yes ___No
Assisted living with individual living, sleeping, bathing, and cooking areas	___Yes ___No
Community-based residence with fewer than four unrelated individuals	___Yes ___No

c. **Services and supports**

Personal emergency response services	___Yes ___No
Respite care	___Yes ___No
In-home aide services	___Yes ___No
Preparation and delivery of meals	___Yes ___No
Specialized equipment or supplies	___Yes ___No
Consumer-directed care advisory	___Yes ___No
Consumer-directed financial management	___Yes ___No
Augmentative communications	___Yes ___No
Home modifications	___Yes ___No
Non-medical transportation	___Yes ___No
Specialized consultative services	___Yes ___No
Home modifications	___Yes ___No
Vehicle adaptations	___Yes ___No
Transition expenses	___Yes ___No

d. Need immediate and consistent access to quality healthcare? ☐ Yes ☐ No

e. Behavioral supports and crisis services that meet your needs? ☐ Yes ☐ No

Surveyor's Comments:

## Attachment C

### Contract of Responsibility

I, \_\_\_\_\_ (name) [or my legal guardian \_\_\_\_\_]

understand that I am being served by Transition coordinator,

\_\_\_\_\_ (name) from the \_\_\_\_\_ (organization).

In receiving services from this organization, I will develop an independent living plan. The plan will include my goals and steps for reaching my goals. The plan will be based on my goals and choices, an independent living evaluation and other pertinent information. I agree to work in partnership with the organization to achieve my goals in the manner and time agreed upon by the staff person and me. Anytime I choose to end this relationship, I may do so by notifying the staff member of my decision in writing or another alternative format. Failure to meet my responsibilities in the plan shall be cause for the organization either to revise the plan or terminate the contract.

I understand that the organization and its employees, working to achieve the objectives of the plan, are not themselves making medical decisions or making decisions about the transition process for me. The organization and its employees are not responsible for any consequences to my health resulting from a transition to community-based care and/or a residential setting.

The risks of transitioning to the community have been explained to me.

I understand that the \_\_\_\_\_ staff person is obligated in aiding the transition from the initial planning stage through the actual transition and follow up (can be up to 365 days) but is not going to act as my permanent case manager.

I authorize the \_\_\_\_\_ staff person to share information that is reasonably necessary (including health information) to assist me in achieving my goals with members of the transition team. I can revoke this consent at any time.

Consumer signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

Witness signature \_\_\_\_\_ Date \_\_\_\_\_

Family member \_\_\_\_\_ Date \_\_\_\_\_

## Attachment D

### The North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) Introduces...

#### *The Money Follows the Person Demonstration Grant project!*

##### **What does “Money Follows the Person” mean?**

When people who are elderly or have disabilities need personal assistance, they often have to go to a nursing home or an institution in order for Medicaid to pay for it. However, many folks would prefer to receive these services in their own homes and in their own communities.

*Money Follows the Person* is the term describing the practice of Medicaid allowing these same people to move *out* of nursing homes and institutions and receive the assistance they need to live in their homes and communities. Thus, the **money** for the assistance **follows** the **person** out of the nursing home or institution and into their homes and communities.

##### **Why is this called a “Demonstration Project?”**

The federal government is awarding extra funding and assistance to states wishing to **demonstrate** how state Medicaid agencies can effectively develop “Money Follows the Person” practices. This funding is time-limited and each state must agree to move people from institutional settings to home and community-based settings.

North Carolina was awarded its Money Follows the Person Demonstration Grant in May 2007.

##### **What is the purpose of North Carolina’s Money Follows the Person Demonstration Grant Project?**

Reorganizing Medicaid services to enable **money** to **follow** people out of institutions is a very complex process. It involves shifting state policies, rules and regulations, adjusting Medicaid funding streams, and supporting local communities so people who are elderly or have disabilities can come home.

The purpose of the Money Follows the Person Demonstration Grant is to provide the state with additional funding and support so it can assist 552 people to move from institutional settings to home and community-based settings and also ensure this continues after the grant ends.

##### **Who will benefit from the Money Follows the Person Demonstration Grant project?**

During the course of the Project, North Carolina wants to support **at least** 552 people who are currently in nursing homes or institutions to move from institutional care to

home and community-based services. These people will be made up of senior citizens, people with developmental disabilities, people with physical disabilities and people with mental illness.

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**How long will the Money Follows the Person Demonstration Grant project last?**

Until September 30, 2011.

**What happens when the Money Follows the Person Demonstration Grant project is over?**

Hopefully, the state will have the structures and supports in place to begin supporting **anyone** who is eligible to receive services in a nursing home or institution to receive those same services in their homes and communities.

**How is the Money Follows the Person Demonstration Grant project different from other Money Follows the Person advocacy efforts in North Carolina?**

In addition to North Carolina's Money Follows the Person Demonstration Grant project, there is also a Money Follows the Person grass-roots advocacy effort. This grass-roots advocacy effort is promoting *state legislation* that will allow anyone who is eligible to receive personal care in a nursing home or institution to receive those same services in their homes and communities. The Money Follows the Person Demonstration Grant project (*a federally funded initiative*) targets 552 people in North Carolina, while the Money Follows the Person grassroots effort is advocating for everyone to have this option.

The two efforts have the same goal: to support people to live in their homes and communities.

**Who do I contact if I want more information on the Money Follows the Person Demonstration Grant project?**

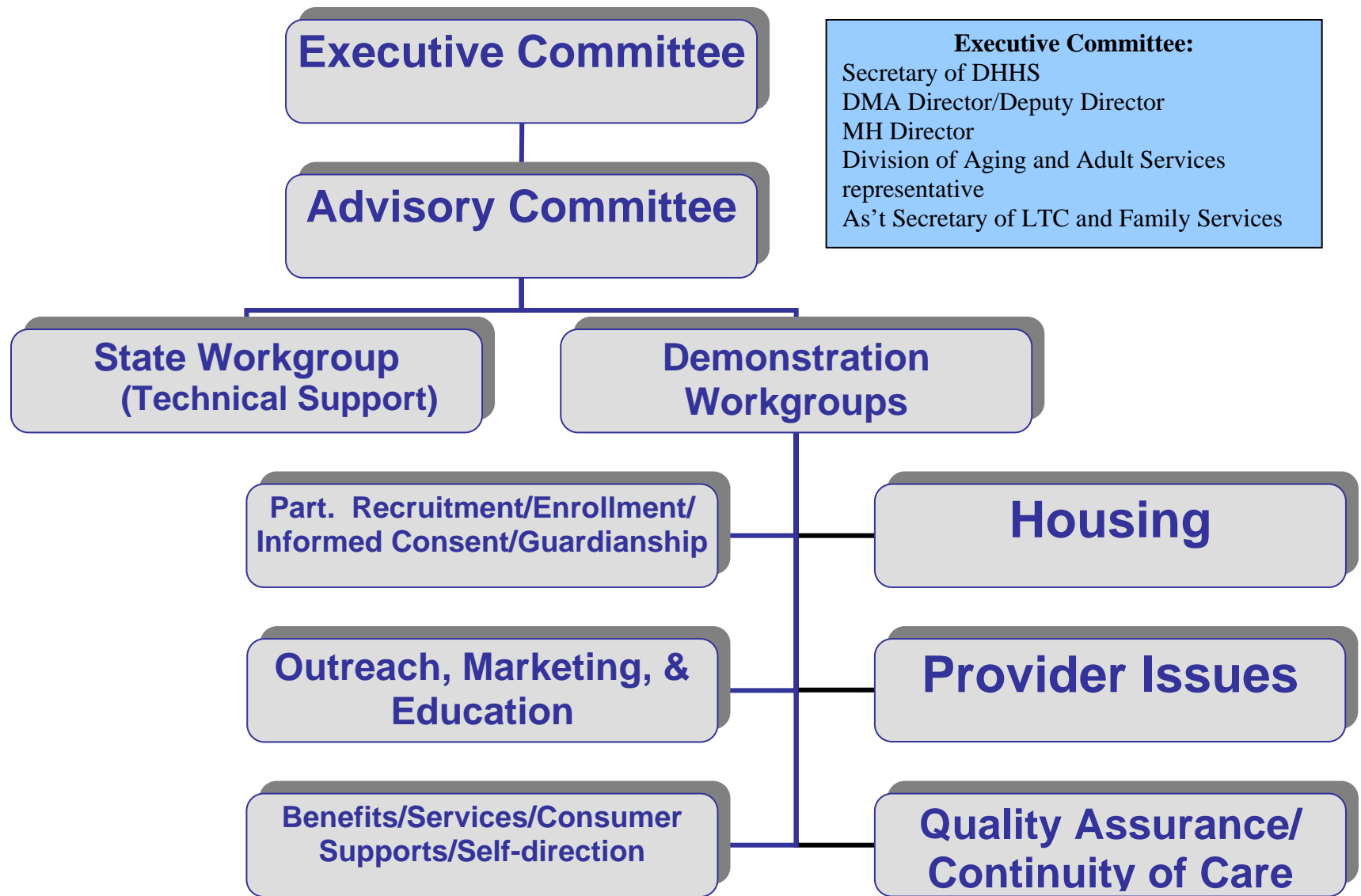
Linda Hicks, Project Director  
919-855-4260 or [linda.m.hicks@ncmail.net](mailto:linda.m.hicks@ncmail.net)

**Is there a website where I can learn more about North Carolina's Money Follows the Person Demonstration Grant project?**

North Carolina Division of Medical Assistance has created a site for the Money Follows the Person Demonstration Grant project. Please visit <http://www.ncmfp.com>.


The North Carolina Disability Action Network (NCDAN) is following the Money Follows the Person Demonstration Grant project's progress and has lots of useful information including a link to the site above. NCDAN's website: [www.ncdan.com](http://www.ncdan.com)

## Attachment E



Each Demonstration workgroup has a State and non-State employee facilitator and is composed of providers and consumers.

## Attachment F (Opening page of NCCareLink website)

- 
- Text Size:  
- [Help](#)
- [Contact Us](#)



- [Home](#)
- [Search By Keyword](#)
- [Search By Topics](#)
- [My NCCareLINK](#)

## Welcome to North Carolina's careLINK A comprehensive health and human services web site.

This website provides up-to-date information about programs and services across North Carolina for families, seniors, youths and everyone in-between. It is a collaborative effort of the North Carolina Department of Health and Human Services and many other government and non-profit information and referral stakeholders across North Carolina. Click the Start a Search button to get started.

## Neighborhoods



### [Services for Veterans](#)

The Veterans and their Families Resources Neighborhood is a statewide link to assist veterans and their families find a variety of programs. This section can assist the veteran in finding services including Veterans Benefits Assistance, Financial Assistance, Hospital and Medical Services, Counseling Services and other veteran related services.



### [Family and Children Resources](#)

The Family and Children Resources Neighborhood is a statewide link to help you meet the wide spectrum of needs of your children or family. This section of NCCareLink will help you connect to resources that will allow you and your family to achieve self sufficiency. You will be able to link to a variety of services including resources for day care, medical care, education, child support, adoption and foster care, assistance with food and clothing needs and much more.



### [Services for Older Adults](#)

The Services for Older Adults Neighborhood of NCcareLINK will help seniors, their families, and caregivers focus on finding the help they need. This is your direct link to a variety of services including: adult day care programs and nursing homes, employment, family and caregiver support programs, health, housing and long term care options.



### [People with Disabilities Connection](#)

The People with Disabilities Connection Neighborhood is a statewide link to resources and services. This is your connection to a variety of resources that will help you in achieving equal access, effective communication and a better quality of life. Some services include supports for living independently, residential care, communication and technology, community advocacy and employment.

## Take Me To . . .

### [Find My Vet Center](#)

Vet Centers provide readjustment counseling and outreach services to all veterans who served in any combat zone. Services are also available for their family members for military related issues. Veterans have earned these benefits through their service and all are provided at no cost to the veteran or family.

### [Provider Portal](#)

The provider portal section allows resource providers access to their existing information for updating purposes. The provider portal also allows new resource providers to add their information and to become an essential resource to the community. Click on the "Provider Portal" link above to go there.

### [Partners Page](#)

NCcareLINK is a collaboration of partners throughout North Carolina, that provide the most current resource information. [Click to visit the NCcareLINK partners page.](#)



## Sign In to Save Resources

If you are already a registered user, sign in below. If you'd like to register, go to the [registration page](#).

Note: User ID and Password are case-sensitive.

User ID  Password   ☐ Remember Me

[Forgot Your Password?](#)

[Forgot Your User ID?](#)

[Need to Register?](#)

[How We Protect Your Privacy](#)

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## Opening page for link to People with Disabilities Connection on NCCareLink resource website



- [Home](#)
- [Search By Keyword](#)
- [Search By Topics](#)
- [My NCCareLINK](#)

## People with Disabilities Connection

The People with Disabilities Connection Neighborhood is a statewide link to resources and services. This is your connection to a variety of resources that will help you in achieving equal access, effective communication and a better quality of life. Some services include supports for living independently, residential care, communication and technology, community advocacy and employment.

## Popular Search Topics

- [Caregiver Supports](#)
- [Chemical & Mental Health](#)
- [Communications](#)
- [Education](#)
- [Employment](#)
- [Financial](#)
- [Food](#)
- [Health Services & Equipment](#)
- [Home and Community Living](#)
- [Housing](#)
- [Legal & Advocacy](#)
- [Leisure](#)
- [Long Term Care Ombudsman](#)
- [Public Benefits](#)
- [Technology & Modifications](#)
- [Transportation & Driving](#)

## Take Me To . . .

[NCCareLINK Main Page](#)

Online access to statewide community resources.

[Find My Vet Center](#)

Vet Centers provide readjustment counseling and outreach services to all veterans who served in any combat zone. Services are also available for their family members for military related issues. Veterans have earned these benefits through their service and all are provided at no cost to the veteran or family.

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User ID  Password   ☐ Remember Me

[Forgot Your Password?](#)

[Forgot Your User ID?](#)

[Need to Register?](#)

[How We Protect Your Privacy](#)

- [Legal](#)
- [Privacy](#)
- [Disclaimer](#)
- [Accessibility Policy](#)
- [Accessibility Tips](#)
- [Technical Problems](#)
- [General Info](#)
- [Satisfaction Survey](#)

## Attachment G

### Self-Direction

#### **I. Participant Centered Service Plan Development**

- a. **Responsibility for Service Plan Development.** Specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

X	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
X	Case Manager. <i>Specify qualifications:</i>
X	Social Worker. <i>Specify qualifications:</i>
	Social Worker I or higher as specified by the North Carolina Office of State Personnel. Social Worker I requires a bachelor's degree in a human services field from an accredited college or university; bachelor's degree from an accredited college or university and one year directly related experience.
<input type="checkbox"/>	Other ( <i>specify the individuals and their qualifications</i> ):

- b. **Service Plan Development Safeguards.** *Select one:*

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other services to the participant.
X	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>
	All lead agencies have a freedom of choice policy and freedom of choice documents that are required to be signed by participants after plan of care development is completed. These documents explain the participant's choice to choose from any qualified provider for their traditional services at any time, upon request. Additionally, participants in this waiver have the extra responsibility of choosing and directing other specific waiver services (e.g. personal assistant, respite, supplies, etc.). A backup plan is developed to assure that the needed assistance will be provided if any key supports identified in the plan are temporarily unavailable. Participants are also informed of due process rights if they disagree with any decisions made by the care advisor. Consultants from Division of Medical Assistance conduct agency reviews and review plans. Additional monitoring of services is given in situations where the entity providing care advisement also provides another waiver service. This occurs sometimes in more rural regions of North Carolina.

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The care advisor assists the participant in assessing individual needs and developing a plan of care including a participant-directed budget. The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate. The care advisor monitors the provision of care and expenditures and maintains contact with the participant to assure the needed care is being provided. The care advisor is also responsible for identifying the need for a representative and assuring that representatives are capable of meeting the needs of the participant.

The role of participants is greater in CAP/Choice than in the traditional program CAP/DA. In CAP/CHOICE participants have more control over resources. With this increased control comes increased responsibility. The key responsibilities of the participant or designated representative are:

- Develop a plan of care with assistance/support from the care advisor;
- Recruit, hire, and manage personal assistant and other individual providers of participant-directed services;
- Prepare an outline of duties and work schedule for personal assistant;
- Negotiate salary and benefits with the assistant;
- Notify assistant of any changes in schedule in a timely manner;
- Train and evaluate personal assistant;
- Negotiate reimbursement or payment rates with individual providers;
- Develop a back-up/emergency plan (alternative caregivers);
- Serve as employer of record for personal assistant;
- Verify accuracy of documentation or provide documentation, as appropriate, to financial manager regarding services provided;
- Report concerns to care advisor about service delivery or representative that affect health and well-being; and,
- Uphold all program agreements as written.

- d. **Service Plan Development Process** In three pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how the MFP demonstration and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) assurance that the individual or representative receives a copy of the plan. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The following individuals are responsible for the preparation of the plans of care:  
The Participant and the care advisor.

(b) A registered nurse and social worker team meet with the applicant/significant others to conduct an assessment and determine the need for a representative.

(c) During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue.

(d) The plan of care and supporting documents are reviewed by and approved by someone at the lead agency other than the care advisor, after agreement and signature by the participant and/or representative and care advisor. Focus is on the ability to meet the identified needs of the participant within the budget limitations whilst maintaining the participant's health, safety and well-being.

The contracted Quality Assurance/Quality Improvement agency, as well as Division of Medical Assistance consultants, is able to perform ongoing review of plans of care as well as more in-depth reviews on site monitoring visits.

(e) The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget according to state requirements.

(f) The care advisor will assist with development of plan of care and emergency/back-up plan; provide information and skills training to participant/participant's representative; provide worker orientation to participant-directed care; monitor plan of care for quality assurance purposes. Also, waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed.

(g) Plans of care are updated as many times as warranted by a change in health status, need, etc. However, re-evaluations of the level of care are required at least annually or sooner if there are indications that the participant's condition/level of care has changed. A new assessment and plan of care are required at the same time as the annual level of care re-evaluation.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The state has procedures to promote family or individual preferences and selections. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

Participants and/or designated representative will be fully involved in the needs assessment process and will select personal assistants based on their (vs. agency) preferences. The participant will train the assistant and determine whether task competencies are met. In assuming these responsibilities, the participant necessarily takes on risk that was previously assumed by provider agencies and program managers. Participants who participate in this program will therefore enter into agreements with the lead agencies which outline rights, risk and responsibilities.

A back-up plan is also developed to assure that the needed assistance will be provided if any key supports identified in the Plan are temporarily unavailable. The Care Advisor provides the information and skills training needed to manage one's own care in the areas of rights and responsibilities of both the Consumer and Worker; recruiting and hiring workers; developing schedules and outlining duties; supervising and evaluating workers; reporting on personal assistance expenditures; and other relevant information and training.

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the services in the service plan.

The care advisor is available to the participant throughout the planning and service delivery process to provide skills training and information relevant to home care, worker employment, etc. The amount of assistance from the advisor will vary from participant to participant depending upon need. Care advisors are to make available to the participant a comprehensive list of qualified providers in, or having the ability to provide services in the applicable service area. This list will be made available upon the participant's or the representative's request.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency or other agency operating the MFP demonstration project:

The same basic care planning process currently used in the elderly/disabled Home and Community Based Services waiver, CAP/DA, will apply to CAP/Choice with the addition that the process will be guided by principles of participant-directed care. Currently the steps in the entry process are:

1. During the intake process, a care advisor or case manager knowledgeable of participant-directed care provides information on both the traditional and participant-directed care program and the applicant decides which program he/she wishes to pursue;
2. A health care professional along with the planning team meet with the applicant/significant others to conduct an assessment and determine the need for a representative;
3. The care advisor assists the applicant in developing a plan of care including both unpaid and paid services, and calculates the participant budget;
4. The care advisor submits the plan to the designated position in the lead agency for approval.
5. Once approval is obtained, services are implemented by the care advisor or participant, as specified in the plan; and,
6. Post-approval reviews by Carolinas Center for Medicaid Excellence quality assurance processes and Division of Medical Assistance consultants are conducted as requested or Plan is sent to Division of Medical Assistance.

- h. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for the duration of time that the state is operating the Money Follows the Person project plus one year. For example, if the state enrolls individuals into the MFP program for three years the state must retain all service plans for four years time (the three years of the demo plus one additional year.) Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other ( <i>specify</i> ):
	Lead agencies in each county. Note: due to the current use of the AQUIP, an automated assessment and plan of care system, the Division of Medical Assistance has access to electronic records via a secured website at any time.

## **II. Service Plan Implementation and Monitoring**

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) Care advisors and CAP/Choice program consultants ensure that waiver services are furnished in accordance with the plan of care by maintaining regular contact with the participant and/or designated representative. Monthly contact is required via telephone and/or home visit. Home visits are required a minimum of quarterly.

(b) & (c) Method and Frequency of Oversight/Monitoring: Waiver program consultants from the State Medicaid agency conduct annual, on-site program reviews and assist/advise with local operation of the waiver program as needed. These visits occur every 12-18 months.

**b. Monitoring Safeguards. Select one:**

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may not provide</i> other direct waiver services to the participant.
X	<p>Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i></p> <p>(a) Adequate standards for all types of providers that furnish services under the waiver.</p> <p>(b) Assurance that applicable state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements will be met on the date that the services are furnished.</p> <p>(c) Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities. Participants are provided the freedom of choice amongst providers and are educated on all due process rights. Division of Medical Assistance consultants provide technical assistance and review this information on request and/or at program site visits.</p>

**III. Overview of Self-Direction**

- a. Description of Self-Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the demonstration, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the demonstration's approach to participant direction.

- (a) Under CAP/Choice, participants will be able to:
- Choose (hire) the personal assistant who will provide their care;
  - Train, supervise and evaluate the worker;
  - Negotiate the rate of pay and other benefits;
  - Release the worker should this become necessary;
  - Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3 of the waiver amendment); and,
  - Engage in a cooperative working arrangement with a financial manager who will pay the client's worker, handle federal/state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the participant.
- (b) The program affords increased participant choice and independence in meeting home care needs and increasing satisfaction with long term supports. To be eligible for CAP/Choice an individual must:
- Live in the geographic areas where CAP/Choice is available;
  - Meet basic criteria to be assessed for home and community based services waiver participation e.g., at risk of institutional care;
  - Be eligible for Medicaid; and,
  - Understand the rights and responsibilities of directing one's own plan of care and be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility
- (c) Division of Medical Assistance, Local Lead Agencies, Financial Management Agencies, Waiver Service Providers and other providers interacting with and participating in the participant's plan of care.

- b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the demonstration. *Select one:*

<input type="radio"/>	<b>Participant—Employer Authority.</b> As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide demonstration services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	<b>Participant—Budget Authority.</b> As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant's representative) has decision-making authority over a budget for demonstration services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	<b>Both Authorities.</b> The demonstration provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence (whether owned or leased) or the home of a family member.
<input type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other community-based living arrangements where services (regardless of funding source) are furnished to four or fewer persons unrelated to the proprietor.
<input type="checkbox"/>	The participant direction opportunities are available to persons residing in a leased apartment, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or individual's family has domain and control.

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

<input checked="" type="radio"/>	The demonstration is designed to afford every participant (or the participant's representative) the opportunity to elect to direct demonstration services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The demonstration is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

<p>(a) Under CAP/Choice, participants will be able to:</p> <ul style="list-style-type: none"> <li>• Choose (hire) the personal assistant who will provide their care</li> <li>• Train, supervise and evaluate the worker</li> <li>• Negotiate the rate of pay and other benefits</li> <li>• Release the worker should this become necessary</li> <li>• Select individual providers and direct reimbursement for several other waiver services</li> <li>• Engage in a cooperative working arrangement with a financial manager who will pay the client's worker; handle federal/state taxes and other payroll or benefits related to the employment of the worker; and reimburse other service providers under the direction of the participant</li> </ul> <p>(b) The lead agency will give each Home and Community Based Services waiver applicant a choice between the traditional program and the new participant-directed model. In making this decision a participant/representative will be educated on the benefits and responsibilities of the participant-directed model.</p> <p>(c) The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate prior to implementation of participant-directed services. The advisor monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided on a continuing basis. Care Advisors will participate in training and have access to materials with a participant-directed focus.</p>
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- f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of demonstration services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of demonstration services by a representative.
<input checked="" type="radio"/>	The State provides for the direction of demonstration services by a representative. Specify the representatives who may direct demonstration services: ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/>	Demonstration services may be directed by a legal representative of the participant.
<input checked="" type="checkbox"/>	<p>Demonstration services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of demonstration services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:</p> <p>The representative may NOT also be the paid caregiver (i.e. personal assistant) for the participant. The representative cannot be paid for the service and must meet the following requirements:</p> <ul style="list-style-type: none"> <li>• demonstrate knowledge and understanding of the participant's needs and preferences;</li> <li>• agree to a predetermined level of contact with the participant;</li> <li>• be willing to comply with program requirements;</li> <li>• be at least 18 years of age; and,</li> <li>• be approved by the participant to act in this capacity.</li> </ul> <p>The Care Advisor plays a significant role in identifying the need for a representative and assuring that the representative meets the criteria outlined above. Additionally, the care advisor, as part of ongoing monitoring activities, assures that the representative continues to act in the best interest of the participant.</p>

- g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each demonstration service. (*Check the opportunity or opportunities available for each service*):

Participant-Directed Demonstration Service	Employer Authority	Budget Authority
Respite Services (In-Home)	X	X
Financial Management Services	X	X
Home Modifications and Mobility Aids	X	X
Consumer-Directed Goods and Services	X	X
Personal Assistant Services	X	X
Waiver Supplies	X	X

- h. Financial Management Services.** Generally, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the demonstration participant. *Select one:*

<input checked="" type="checkbox"/>	<b>Yes.</b> Financial Management Services are furnished through a third party entity. ( <i>Complete item E-1-i</i> ). Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input checked="" type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="checkbox"/>	<b>No.</b> Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a demonstration service or as an administrative activity. *Select one:*

<input checked="" type="checkbox"/>	FMS are covered as a Demonstration service	Fill out i. through iv. below:
<input type="checkbox"/>	FMS are provided as an administrative activity. Fill out i. through iv. below:	
	<b>i.</b>	<b>Types of Entities:</b> Specify the types of entities that furnish FMS and the method of procuring these services: Fiscal Employer Agency
	<b>ii.</b>	<b>Payment for FMS.</b> Specify how FMS entities are compensated for the activities that they perform: FM is billed in units of 15 minutes. FM is allowed to bill up to 6 units for the startup month and up to 4 units per month thereafter. Total units in a year cannot exceed 50.
	<b>iii.</b>	<b>Scope of FMS.</b> Specify the scope of the supports that FMS entities provide ( <i>check each that applies</i> ): <i>Supports furnished when the participant is the employer of direct support workers:</i>
	<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status
	<input checked="" type="checkbox"/>	Collect and process timesheets of support workers
	<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	<input checked="" type="checkbox"/>	Other ( <i>specify</i> ): Financial Management Services are provided to assure that participant-directed funds outlined in individual plans of care are managed and distributed as intended. The Financial Manager files claims through the MMIS for participant-directed goods and services and reimburses individual providers. The FM deducts all required federal, state and local taxes, including unemployment fees, prior to issuing reimbursement or paychecks. The Financial Manager entity is responsible for maintaining separate accounts on each participant's services funds and producing expenditure reports as required by the State Medicaid agency. The Financial Manager also provides reports on at least a monthly basis to the participant. The Financial Manager conducts criminal background checks and age verification on personal assistants as requested by the participant.

		<i>Supports furnished when the participant exercises budget authority:</i>	
	<input checked="" type="checkbox"/>	Maintain a separate account for each participant's self-directed budget	
	<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds	
	<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan	
	<input checked="" type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the self-directed budget	
	<input type="checkbox"/>	Other services and supports ( <i>specify</i> ):	
		<i>Additional functions/activities:</i>	
	<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	
	<input type="checkbox"/>	Other ( <i>specify</i> ):	
<b>iv.</b>	<b>Oversight of FMS Entities.</b> Specify the methods that are employed to: (a) monitor and assess the performance of Financial Manager Services entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.		

- j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	<b>Case Management Activity.</b> Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the demonstration:</i>
<input checked="" type="checkbox"/>	<b>Demonstration Service Coverage.</b> Information and assistance in support of participant direction are provided through the demonstration service coverage (s) entitled:
	Care Advisory, Financial Management Services

<input type="checkbox"/>	<p><b>Administrative Activity.</b> Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the demonstration; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i></p>

**k. Independent Advocacy (select one).**

<input checked="" type="checkbox"/>	<p><b>Yes.</b> Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p>
	<p>1) North Carolina's Long Term Care Ombudsman Program consists of state and regional ombudsmen who help residents of long-term-care facilities to exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff about rights and help resolve grievances between residents/families and facilities. The regional ombudsmen, who are located within Area Agencies on Aging, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (N.C.G.S. 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in long-term-care facilities. There are over 1,100 such volunteers statewide, with committees in each county. The services provided by the Ombudsman Program include:</p> <p>A. Answering questions and giving guidance about the long term care system. An ombudsman will:</p> <ul style="list-style-type: none"> <li>• explain long term care options.</li> <li>• give pointers on how to select a long-term-care facility provide information on specific facilities (such as the latest and past certification reports and complaint information).</li> <li>• explain residents' rights and other federal and state laws and regulations affecting long-term-care facilities and residents.</li> <li>• give guidance on the Medicaid and Medicare programs--specifically qualification criteria, application procedures and what services these programs cover.</li> <li>• give guidance on such matters such as powers of attorney, living wills and guardianship.</li> </ul> <p>B. Educating community groups and long term care providers on various topics such as residents' rights, restraint use, care planning, activities and new laws.</p>

	<p>C. Investigating and assessing matters to help families, residents and families resolve concerns and problems. Common areas of complaints include:</p> <ul style="list-style-type: none"> <li>• medical and personal services being provided to residents such as problems with medication, nutrition and hygiene.</li> <li>• financial concerns such as handling of residents' funds, Medicare, Medicaid, and Social Security.</li> <li>• rights of residents, such as the right to be treated with courtesy and to have individual requests and preferences respected.</li> <li>• nursing home administrative decisions, such as admission to or discharge from a facility.</li> </ul> <p>D. Working with appropriate regulatory agencies and referring individuals to such agencies when resolutions of issues are not possible through the Ombudsman Program alone.</p> <p>E. Raising long term care issues of concern to policymakers.</p> <p>2) County Adult Protective Service programs are required to investigate and act upon any allegations of abuse, neglect, and exploitation of the participant.</p> <p>3) The participant has the opportunity to self-advocate through participation in local non-profit advocacy groups, such as Centers for Independent Living, the Participant Task Forces of various state programs and initiatives (e.g. - Rebalancing Grant, Money Follows the Person Demonstration, Systems Transformation Grant, etc), and input into the State Independent Living Council.</p>
○	<b>No.</b> Arrangements have not been made for independent advocacy.

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A Care advisor works with the participant to transfer to an alternate waiver or other state plan service(s) and monitors health and safety until the new service is fully implemented.

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the care advisor will work with the participant to resolve them. If they cannot be resolved, the participant will be removed from the program and assessed for the traditional home and community based services program, CAP/DA. Care advisors/lead agencies will consult with Division of Medical Assistance program consultants prior to taking any action.

Participants who demonstrate the inability to self-direct waiver services, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, will be required to select a representative to assist them with the responsibilities of self-direction. If a participant refuses to select a representative or if participant loses a representative and cannot locate a replacement, they will be required to transfer to another waiver program that has traditional agency oversight. Care advisors will assist the participant in the transition. Participants are given due process rights for any changes in service and/or termination/removal of a service/program.

Note: Participants may also voluntarily terminate participant direction in favor of returning to CAP/DA.

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the demonstration is in effect for the unduplicated number of demonstration participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their demonstration services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Demonstration Year	Number of Participants	Number of Participants
Year 1 (2008)		0
Year 2 (2009)		2
Year 3 (2010)		2
Year 4 (2011)		1
Year 5		N/A

#### Participant Employer

- a. **Participant—Employer Authority** (Complete when the demonstration offers the employer authority opportunity as indicated in Item E-1-b)

- i. **Participant Employer Status.** Specify the participant's employer status under the demonstration. Check each that applies:

<input type="checkbox"/>	<b>Participant/Co-Employer.</b> The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide demonstration services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:

X	<b>Participant/Common Law Employer.</b> The participant (or the participant's representative) is the common law employer of workers who provide demonstration services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
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- ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide demonstration services. *Check the decision making authorities that participants exercise:*

X	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input type="checkbox"/>	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated: The financial manager does this upon request of the participant. The cost is incorporated into the financial management reimbursement.
X	Specify additional staff qualifications based on participant needs and preferences
X	Determine staff duties consistent with the service specifications
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets
X	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other ( <i>specify</i> ):

- b. **Participant—Budget Authority** (*Complete when the demonstration offers the budget authority opportunity as indicated in Item E-1-b*)

- i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget
<input checked="" type="checkbox"/>	Determine the amount paid for services within the State's established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications
<input checked="" type="checkbox"/>	Specify how services are provided,
<input type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for demonstration goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other ( <i>specify</i> ):

- ii. **Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for demonstration goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

**Methodology for Calculation of Individual/Participant-Directed Budget:**

Budgets will be calculated based on the methodology in place for the CAP/DA waiver currently serving the elderly/disabled. The process involves an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each service is calculated. The cost of all services cannot exceed the average per capita cost to Medicaid of nursing facility care. Additionally, there is monthly individual budget limit, designated by level of care, that cannot be exceeded.

The budget will contain both agency and participant-directed services, as outlined below. Those designated as participant-directed will constitute the individual budget to be directed by the participant.

**Agency-Directed:**

Adult Day Health Care  
Care Advice  
Financial Management  
In-Home Aide  
Institutional Respite  
Preparation & Delivery of Meals  
Telephone Alert

**Participant-Directed:**

Participant-Designated Goods & Services (additional limit of \$600/year)  
Home Modifications and Mobility Aids\* (additional limit of \$1500/year)  
Personal Assistant

**Respite (In-Home)**

**Waiver Supplies\***

\*Indicates service may be either participant or agency directed

It is recognized that actual utilization of services authorized does not equate to 100%—for example, participants are hospitalized, aides miss visits and substitutes are not available. (\*North Carolina Division of Medical Assistance requires a minimum of monthly monitoring of all waiver services, including the participant's emergency back-up plan. If it is determined the participant's needs are not being met the plan of care is modified to address these needs. New supports and services are identified and put in place to meet these needs. If these needs continue to go unmet or the participant's health and well-being are at risk other programs may be identified that better serve the participant.) Based on findings of the National Cash & Counseling Demonstration, at least 10 to 20% of personal care services authorized in the traditional delivery system is not used. In addition, many of the indirect costs which are built into the payment rates such as professional supervision and training of workers, office space, equipment, supplies, etc., are not applicable to the participant-directed model. Therefore, the maximum hourly rate for personal assistant services will be 10 to 20 percent lower than the current Medicaid personal care rate. Individuals may negotiate personal assistant payment rates lower than the maximum, thereby enabling them to set aside a portion of their budget for other services such as participant-designated goods and services which would increase independence.

Participants will have considerable flexibility in using funds designated as participant-directed. They will be able to substitute services and/or reschedule services within the budget without agency approval in certain cases.

The methodology will be explained to the participant/representative by the care advisor. The care advisor will point out both the added responsibilities if this model is selected and its benefits. The Individual/Participant-Directed Budget will be re-determined at least annually and more frequently depending on changes in the Participant's situation. The methodology will be published in the operations manual for this program. All Medicaid policy and program manuals are available for public inspection.

- iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant must be informed of the amount of the individual budget during and after the service plan development process. Participants may inquire about the balance of their account throughout waiver enrollment from his/her care advisor in addition to an annual evaluation.

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

X	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	Participants have the authority to modify the timing of service delivery (ex. personal assistant hours). Otherwise, modifications to the participant-directed budget must be preceded by a change in the service plan after discussion with the care advisor.

○

Modifications to the participant-directed budget must be preceded by a change in the service plan.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

At the local level plans of care and service provision will be continually monitored by the care advisor to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified the care advisor will work with the participant to resolve them. If the problem(s) is not resolved, care advisors/local lead agencies will consult with Division of Medical Assistance program consultants prior to taking any adverse action towards a participant.

Additionally, post-approval and post-payment reviews are conducted by Carolinas Center for Medicaid Excellence and Division of Medical Assistance consultants.

## **Attachment H**

### **Quality Management Strategy—CAP/Choice**

North Carolina Department of Health and Human Services

Division of Medical Assistance

*(Excerpt from CAP/Choice Waiver Application Amendment, Appendix H)*

#### **I. Waiver Assurances**

##### **Level of Care Determination**

North Carolina Medicaid requires that a level of care determination be made on all participants seeking home and community based services, including CAP/Choice, by using a standardized screening tool (currently the FL-2 form) for determining nursing facility level of care.

Procedures exist to assure that individuals reflect nursing facility level of care after a complete assessment. Level of care is re-evaluated annually.

Each time a CAP/Choice participant assessment is completed in Automated Quality and Utilization Improvement Program (North Carolina's automated assessment, care planning and quality assurance tool implemented and maintained through state contract), certain information fields are analyzed resulting in a Resource Utilization Group Resource Utilization Group score being assigned to the participant. Since CAP/Choice participants must qualify for nursing facility level of care, the Resource Utilization Group score determined by Automated Quality and Utilization Improvement Program incorporates the same data elements as the national system.

##### **Plan of Care**

In North Carolina, the local lead agency assures that comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan. Local lead agencies assure that plans of care address all assessed needs and personal goals, either by waiver services or other means. Additionally, they assure that participants are afforded choice among service providers, that participants and/or their legal responsible party actively participate in the plan of care development, and that plans of care are updated or revised when warranted by changes in the waiver participant's needs.

##### **Qualified Providers**

For provider directed services, North Carolina Medicaid verifies that providers meet required licensing/certification standards and that staff have demonstrated competency to perform tasks. In addition to licensure standards, North Carolina Medicaid requires providers to submit a North Carolina Medicaid CAP/Choice Provider Enrollment Application. As part of the routine monitoring, Division of Medical Assistance reviews these providers to assure adherence to

waiver requirements. For participant-directed services where the participant has "employer authority", the participant determines the qualifications of the individual provider.

## Health and Welfare

Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant. Division of Medical Assistance has mandatory reporting requirements for all providers. North Carolina statutes require any person having reasonable cause to believe that a disabled adult is in need of protective services shall report (either orally or in writing) such information to the director of the county department of social services. County departments of social services must accept all reports alleging an abused, neglected or exploited disabled adult is in need of protective services.

In addition to reports of abuse, neglect or exploitation, critical events include decline in mental or physical health and/ or loss of informal support that effect the ability of the participant to self direct. If this occurs, care advisors reassess the participant's situation to determine whether the participant-directed option continues to be appropriate for the individual. Personal assistants and other direct workers who are in touch with the participant on a regular basis are instructed to report problems to the care advisor.

## Administrative Authority

Division of Medical Assistance retains ultimate authority and responsibility for the operation of the waiver by exercising oversight over the performance of waiver functions by local lead agencies and contracted entities. Specifically, state level CAP/Choice consultants conduct on site compliance reviews and Division of Medical Assistance contracts with The Carolinas Center for Medical Excellence for ongoing quality assurance and utilization management functions. CAP/Choice consultants have "real time" access to assessments, plans of care and quality indicators.

North Carolina Medicaid, through a contract with a fiscal agent, Electronic Data Systems Corporation, is responsible for ensuring that CAP/Choice claims are paid correctly. Electronic Data Systems Corporation has established edits and audits in the claims payment system to ensure payment is made in accordance with the approved methodology.

## **II. Roles and Responsibilities**

### Participant Role:

The role of participants is greater in CAP/Choice than in the traditional program, in that they have significantly more control over resources. With this increased control comes increased responsibility. The key responsibilities of the participant/designated representative are:

- Develop a plan of care with assistance/support from the care advisor
- Recruit, hire, and manage personal assistant and other individual providers of participant-directed services
- Prepare an outline of duties and work schedule for personal assistant

- Notify assistant of any changes in schedule in a timely manner
- Train and evaluate assistant
- Negotiate salaries and benefits of personal assistant employee
- Negotiate reimbursement or payment rates with individual providers
- Develop a back-up/emergency plan (alternative caregivers)
- Serve as employer of record for personal assistant
- Verify accuracy of documentation or provide documentation, as appropriate, to Financial Manager regarding services provided
- Report concerns to care advisor about service delivery or representative that affect health and well-being
- Uphold all program agreements as written

#### Representative Role:

The representative may be a family member, friend, legal guardian, other legally appointed representative, or income payee. The representative cannot be paid for the service and must meet the following requirements:

- Demonstrate knowledge and understanding of the participant's needs and preferences
- Agree to a predetermined level of contact with the participant
- Be willing to comply with program requirements
- Be at least 18 years of age
- Be approved by the participant to act in this capacity

#### Care Advisor Role:

The care advisor is a specialized case manager with an understanding of participant-directed care and the ability to facilitate rather than direct care planning and service delivery. Care advisors are registered nurses and social workers who meet the standards described in Appendix B.

- Assists the participant in assessing need and developing a plan of care including a participant-directed budget.
- Provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate.
- Monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided.
- Identifying the need for a representative and assuring that representatives meet the criteria outlined above.

#### Financial Manager Role:

The financial manager bills for participant-directed care services in the individual plan and disburses funds. The Financial Manager:

- Files claims through the MMIS
- Reimburses individual providers
- Makes required payroll deductions
- Conducts criminal background checks and verifies age and qualifications of personal assistants upon request.

#### State Role:

Division of Medical Assistance provides assurances of:

- Health, Safety and Well-Being
- Financial Accountability
- Evaluation of Need
- Choice of Alternative

### **III. Processes to Establish Priorities and Develop Strategies for Remediation and Improvement**

A summary of the results of Division of Medical Assistance's monitoring of participant health and welfare and the continuous improvement of waiver program operations will be submitted annually, as part of the CMS approved reporting forms/process.

**Participant Role:** In opting for self-directed care, the participant or representative assumes responsibility for contacting the care advisor if the participant believes his/her home care needs are not being met and safety and well-being are compromised. The care advisor makes a home visit to evaluate and assist—follow-up is immediate if the situation appears to be an emergency. Examples of situations that would trigger a participant report are: personal assistant repeatedly fails to show up as scheduled; personal assistant exhibits inappropriate behaviors or actions in the participant's presence; informal (non-paid) supports do not follow through with agreed upon assistance.

**Care advisor Role:**

- Provide training to the participant/designated representative on managing services. Orientation to the program is required and will cover participant-directed care principles/philosophy, worker and participant rights and responsibilities, and participation requirements. Additional training on topics such as worker recruitment, reimbursement/rate negotiations, communication and supervision, are also be available. Training may be informal, one-on-one, or conducted in a group setting.
- Review the participant's account at least monthly to monitor service provision. If significant deviations in actual vs. planned spending are occurring, contact with the participant is made to determine if a problem exists.
- Make monthly phone calls to the participant to inquire about any concerns or problems with service provision.
- Conduct a home visit quarterly to review service provision with the participant. Reassessments and plans of care are conducted annually and require home visits; these visits will count toward the quarterly visit requirement.

**Division of Medical Assistance Role:**

- Make on-site visits to review program activities. Division of Medical Assistance waiver program consultants currently conduct annual on-site reviews which include staff interviews, home visits, record reviews and review of operating procedures. The monitoring visits include review of participant accounts/funds disbursement against

- plans of care. A written report is generated and corrective actions for any problems identified are required. A summary report of findings and corrective actions will be submitted to CMS annually.
- Division of Medical Assistance and the lead agencies will work together to administer participant surveys. Questionnaires are sent to a random sample of participants along with a stamped, addressed return envelope. Performance of personal assistants, absences, turnover, supervision, concerns about any unmet needs and feedback on overall program operation are some of the areas that are addressed. Findings from the surveys are used for program improvement; any critical issues will be addressed immediately.

#### **IV Compilation and Communication of Quality Management Information**

North Carolina maintains its contract with the Carolinas Center for Medical Excellence for its quality assurance program review of the assessment, plan of care, service delivery procedures and claims processing for the waiver program. Carolinas Center for Medical Excellence provides an automated review of all CAP/DA and CAP/Choice participants using the Automated Quality and Utilization Improvement Program for Home and Community Based Services. The Automated Quality and Utilization Improvement Program is used to provide descriptive and longitudinal analysis of CAP/DA and CAP/Choice data. Once summary reports are established (on a monthly and quarterly basis), results of these reports for the quality assurance process are used by consulting staff to improve staff training and for identifying areas that indicate the need for consultative assistance to local programs.

The quality assurance review process continues to be a valuable tool for program improvement for both the local and lead administrative agencies and waiver program staff in Division of Medical Assistance Medicaid Agency. A sample of quality indicators include, but are not limited to:

- 30 Days Falls-Initial Assessment
- Unplanned Weight Loss-Initial Assessment
- Unplanned Weight Loss-Other Assessment
- Telephone Alert-Dementia or Alzheimer's
- Medication Confirmation
- Appropriate Use of Pads/Briefs
- Participant perceive they have Necessary Support and Services

Each county will be scored a percentage of each indicator. Each indicator will be measured on a scale from:

- Excellent (highest category)
- Good
- Fair
- Poor (lowest category)

## **V. Periodic Evaluation and Revision of the Quality Management Strategy**

Division of Medical Assistance strategically evaluates its Quality Management System on an annual basis, in addition to providing on-going oversight and monitoring of its waiver program to ensure that each of the CMS assurances are continually met to improved the operation of the program. In strategizing its Quality Management System, reevaluation will involve families/individuals/representatives, providers, and other relevant stakeholders in the process of assessing its long-term goals and objectives. All relevant parties are given timely notice regarding upcoming reevaluations and other operational/procedural changes.

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**Introduction**

The North Carolina public system for mental health, developmental disabilities, and substance abuse services is in the fourth year of a seven-year comprehensive restructuring and reform process that builds on reform legislation passed in 2001. Key components of this reform include:

- Consumer involvement at all levels,
- An emphasis on home and community based services, including CAP-MR/DD waiver design and development to:
  - Address the needs of individuals at the ICF-MR level of care in the community;
  - Provide services and supports that will enable individuals to move from ICF-MR state operated facilities and group homes into the community;
  - Better tailor services to individuals through a person centered approach to planning;
  - Offer service options that will facilitate individuals continuing to live in or return to live in private residences.
- Local accountability,
- Effective services and supports based on evidence-based practices,
- Data-driven and outcomes-focused decision making.

**Design of the Quality Management System**

Development of a Quality Management (QM) system for the CAP-MR/DD waiver and the system as a whole is one of the fundamental building blocks of Mental Health/Developmental Disabilities/Substance Abuse Services reform in North Carolina. It is the intent of the State MH/DD/SAS Plan that a QM system integrates and analyzes information from multiple sources and functions within the state service system. Quality Management processes must be accountable to all stakeholders and findings must be published, including the assessment of quality improvement activities. The specific objectives related to QM are:

- The Division will develop and execute a comprehensive QM system focusing on continuous quality improvement.
- The QM system will be outcome-based.
- Performance indicators for all levels of the system will be included in the QM process.
- The Division will develop measurement criteria for models of best practice to be included in the QM system.
- The Division will establish competency requirements for all segments of the mental health, developmental disabilities and substance abuse services workforce.
- The Division will manage a comprehensive training and education strategy to support the new QM system.

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The redesigned QM system including the CAP-MR/DD waiver, will incorporate the Home and Community-Based Services (HCBS) Quality Framework. The QM Team has identified measures within each of the framework's domains that correspond to the goals of the State Plan and the CAP-MR/DD waiver. **Attachment 1** describes all the measures that DMH/DD/SAS is currently using or plans to use to measure system performance. Some of these measures are currently collected, analyzed, reported and reviewed as part of the LME Performance Contract. Mechanisms for regular collection, analysis and review of data on the other measures are currently being devised.

In addition to these measures designed specifically to support the QM plan, DMH/DD/SAS currently collects a wide range of data on service utilization and cost, consumer outcomes and satisfaction, and special projects. **Attachment 2** summarizes this data, which is available for use in the QM system.

Note that an early product of the work described here will be a State Quality Management Work Plan, detailing how DHHS will meet the QM requirements in the HCBS Draft Waiver application over the course of the 3-year period covered by this application. A key component of the efforts to create a comprehensive QM system is a Real Choice Systems Change Grant for QA/QI in HCBS awarded by CMS in 2003.

While the foundation of the QM system is already in place, the NC MH/DD/SAS is using this grant to complete the development and implementation of the information feedback loops that are critical to a system based on continuous quality improvement. The data and performance measures referenced above will be rolled into a cohesive process where information is used to assure quality and drive system improvement. Toward that end, work under the Systems Change Grant will accomplish the following goals:

- Evaluate the process and outcomes of transitioning consumers from institutional to home and community-based care through data collected in face-to-face interviews with transitioning consumers, using other consumers and family members as interviewers;
- Develop a comprehensive, coordinated system of Quality Improvement (QI) committees among provider agencies, local management entities and the NC Department of Health and Human Services (DHHS);
- Use the transition interview data and QI committees to pilot ways to improve service delivery and consumer outcomes and satisfaction through QI processes;
- Develop a long-term plan for expanding the focus of the QI committees to encompass other populations, services, and processes.

This document describes QA/QI processes that are currently taking place and future QA/QI processes in development are being planned as part of the CMS grant activities. The next section provides an overview of the organizational structure of the system and the responsibilities and activities of the primary entities involved in QM. The section also describes the specific quality assurance activities at the local and State level in regard to the CAP-MR/DD waiver. The remainder of the document is organized around the HCBS Quality Framework domains and the CMS regional review protocol components.

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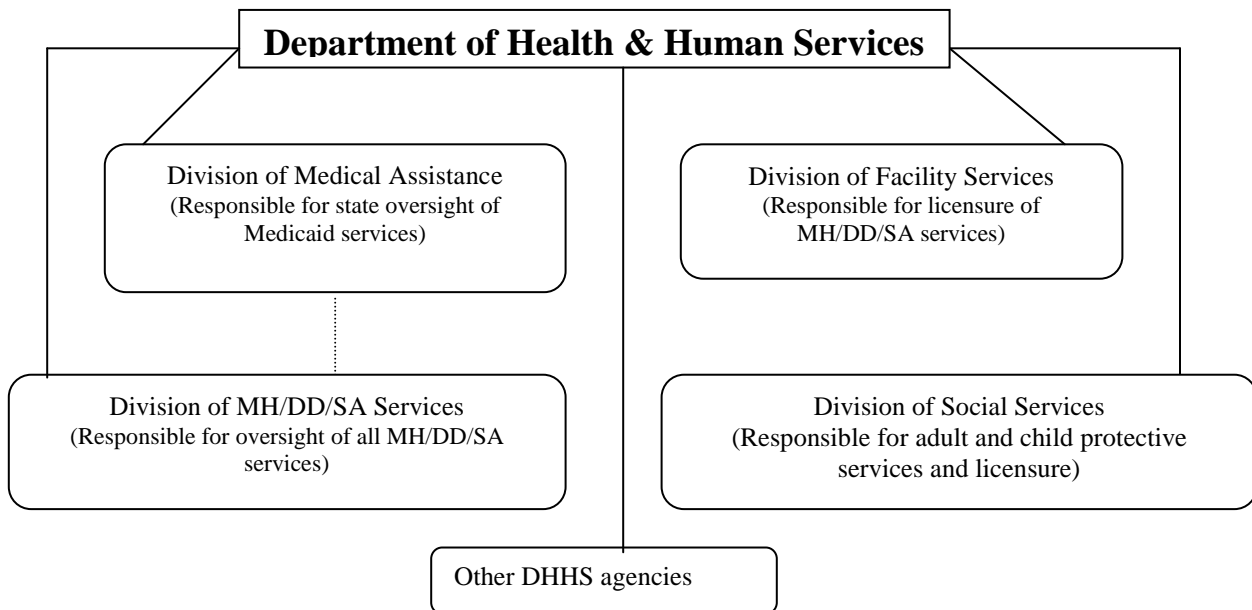
**Organizational Context for Quality Management**

A Quality Management System is built around a coordinated approach that defines, assigns, and interprets quality related activities across various cooperative entities. The following section describes those entities and their respective roles in the North Carolina system.

**State Authority for the Waiver**

According to federal and state guidelines, the NC Division of Medical Assistance (DMA) has responsibility for the overall operation of the HCBS waiver. The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the lead agency for overseeing the daily operations of this waiver. The two Divisions cooperate in the operation of the waiver program under a memorandum of understanding that delineates each Division's responsibilities. The Division of Facility Services (DFS), the Division of Social Services (DSS) and the Division of Aging and Adult Services (DOA) have legally mandated responsibilities for licensure of facilities (DFS) and for child (DSS) and adult protective services (DOA.). All of these Divisions are under the authority of the Department of Health and Human Services (DHHS). These relationships are depicted on the chart in Figure 1 below.

Figure 1: NC Department of Health and Human Services



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**Quality Assurance Responsibilities and Activities within the MH/DD/SAS System**

Quality assurance and improvement responsibilities are shared across multiple entities. The system relies on each entity to fill a distinct role while interacting with the other entities. The North Carolina QM system starts with consumers and their families, and builds in a coordinated way to the highest levels of state oversight.

**Consumers/Families**

Consumers and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:

- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,
- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Local CFACs also participate in a “mystery shopper” evaluation of provider performance and response to service requests.

**Providers**

Provider agencies are responsible for:

- Licensure and certification,
- Providing Targeted Case Management,
- Development of person-centered plan of care,
- Development of internal quality improvement plans,
- Maintaining internal client rights committees.

**Local Management Entities (LME)**

The Local Management Entities (LME) are the local lead agencies for the counties they serve, and are responsible for the administration and operation of MR/DD waiver programs in their areas. The functions of the LME include:

- Local business planning to ensure congruence with the State Plan;
- Governance, management and administration;
- Development of a community of qualified providers;
- Operation of a uniform local access system;
- Evaluation and continuous quality improvement;
- Financial management and accountability;
- Management of secure information systems with data on consumers, providers services and finances;

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- Service monitoring and oversight, including provider compliance with standards, utilization and performance reviews;
- Technical assistance to providers.

LMEs enter into an annual Performance Contract with DHHS that define the responsibilities of the LME as a waiver lead agency and describe performance standards the LMEs are expected to meet.

**North Carolina Department of Health and Human Services**

Figure 1 (above) illustrates the Divisions within the Department of Health and Human Services (DHHS) involved in implementing the HCBS waiver, and describes each of their responsibilities.

- DMA delegates approval authority for the waivers to DMH/DD/SAS and the Local Management Entities (LMEs).
- DMH/DD/SAS has primary responsibility for implementing the QM procedures for the waivers at the state level. These responsibilities include:
  - Ensuring compliance with all state and federal audit requirements;
  - Collecting and managing all program and consumer data;
  - Researching and developing evidence based best practice models;
  - Supporting consumer involvement at all levels of the system;
  - Providing training and technical assistance to LMEs
- DMH/DD/SAS and DMA together are responsible for:
  - Oversight of contracts with Local Management Entities (LMEs);
  - Setting performance standards for LMEs;
  - Monitoring regulatory compliance with state, federal, and waiver requirements

**CAP-MR/DD Waiver Quality Assurance Activities and Frequency of Activities**

Quality Assurance activities begin at the local level with the individual, Consumer and Family Advisory committees, providers, case manager, and the LME. At the state level, activities are completed by the DMH/DD/SAS and DMA in the Department of Health and Human Services (DHHS).

Individuals will:

- Contact their case managers if they have concerns about their services or supports
- Access grievance and complaint processes, with assistance from their case managers, if needed, based on written materials provided by the LME

Individuals and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:

- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,

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- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Provider Agencies will:

- Ensure that staff are qualified to deliver services and receive required supervision
- Monitor the provision of services
- Complete Incident Reports as required by DHHS rules
- Complete Death Reports as required by DHHS rules
- Contact the case manager if there are any concerns about the health or safety of the individual receiving services

The Case Manager will:

- Make a minimum of a monthly face-to-face visit with the individual to inquire about any concern or problem with service provision.
- Reassess each individual's needs at least annually and develop a revised person centered Plan of Care based on that reassessment.
- Follow-up and resolve any issues related to the individual's health, safety, or service delivery. Unresolved issues will be brought to the attention of the LME.

Local Management Entities will:

- Provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. Individuals will also be notified of grievance and complaint resolution processes.
- Resolve issues related to any individual's health, safety or service delivery that are unresolved by the case manager.
- Investigate complaints regarding licensed and unlicensed MH/DD/SAS providers as required by DHHS rules
- Oversee and monitor MH/DD/SAS services provided in the LME catchment area as required by DHHS rules inclusive of provider qualifications
- Receive and review Critical Incident Reports from MH/DD/SAS providers as required by DHHS rules
- Ensure that MH/DD/SAS providers complete death reports as required by DHHS Rules
- Ensure that reporting is made to the County Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that an individual may be abused, neglected or exploited and in need of protective services
- Complete and submit Quarterly Reports to DMH/DD/SAS, and the local Client Rights Committee to include the following:
  - Incidents
  - Complaints concerning the provision of public services
  - Complete and submit a report of monthly local monitoring activities to the Division of Facility Services and DMH/DD/SAS that identifies provider monitoring issues requiring correction and an explanation of uncorrected issues.

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- Provide on-call emergency back-up through the LME to provide staff in the event that the emergency back-up strategies identified in the person centered Plan of Care cannot be implemented and there is potential that the person's health and welfare would be jeopardized.

The DHHS will complete:

- Monitoring of CAP-MR/DD providers. Monitoring includes yearly audits of paid claims to CAP-MR/DD providers. The sample used in determining the providers to be audited is chosen so as to offer statistical assurance of the overall performance of all CAP-MR/DD providers. In addition, providers with previous records of low performance are routinely included in the sample. The State undertakes reviews of local approval protocols for Plans of Care to assure interrater reliability. When there are out-of-compliance findings for any of these reviews or audits, Plans of Correction are required, and the State follows these plans with reviews to assure correction of system issues which contribute to out of compliance findings. Should corrections not be made, the option of suspension or revocation of a provider's privileges to bill is available.
- Investigations of incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the LME. If there are allegations of abuse, neglect or exploitation, a report will be made to the County Department of Social Services. Incidents and complaints regarding licensed facilities are investigated by or jointly with the Division of Facility Services.
- Track requests for reconsideration and resolutions of requests for reconsideration.
- Review Quarterly Reports of monitoring and incidents submitted by the LME.
- Track and investigate deaths of individuals. Deaths of individuals residing in licensed facilities are reported to the Division of Facility Services. Other deaths are reported to DMH/DD/SAS.

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**Quality Measures**

The following table describes the Quality Framework domains that DMH/DD/SAS is currently using or will use to guide the measurement of system performance, both for CAP-MR/DD waiver and the MH/DD/SAS system.

<b>Domain</b>	<b>Desired Outcome</b>
<b>Participant Access</b>	Individuals have ready access to home and community-based services and supports in their communities.
<b>Person Centered Planning and Service Delivery</b>	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
<b>Provider Capacity and Capabilities</b>	There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.
<b>Participant Safeguards</b>	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
<b>Participant Rights and Responsibilities</b>	Participants receive support to exercise their rights in accepting personal responsibilities.
<b>Participant Outcomes</b>	Participants achieve desired outcomes.
<b>Participant Satisfaction (with system and processes)</b>	Participants are satisfied with their services.
<b>System Performance</b>	The system supports participants efficiently and effectively and constantly strives to improve quality.

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**Summary of Quality Management Measures**

The following table summarizes the primary QM features according to the CMS regional review protocol components. These five categories are cross-referenced to the relevant HCBS Quality Framework domains. For each regional review category, the table also lists the key measures of performance that are used to ensure quality in each related domain. The table then summarizes how the Quality Management Plan operationalizes the CMS Quality Framework components of **Design**, **Discovery**, and **Remediation**.

The **System Improvement** component is not included in this table. Please note that the System Improvement component will evolve as a key part of the 3-year Quality Management Work Plan described earlier in this document. The Work Plan will develop the structure within which performance measures and other data will be managed to drive continuous system improvement.

<b>CMS Regional Review Protocol Categories</b>	<b>Related HCBS QF Domains</b>	<b>Key Measures</b>	<b>Design</b>	<b>Discovery</b>	<b>Remediation</b>
<b>Level of Care</b>	Participant Access	<ul style="list-style-type: none"> <li>• Populations served</li> <li>• Timely Access</li> <li>• Notification of denial</li> <li>• Complaints</li> <li>• Service utilization and cost</li> <li>• Penetration rates</li> <li>• “Mystery Shopper”</li> </ul>	<ul style="list-style-type: none"> <li>• Access standards for timeliness</li> <li>• Eligibility criteria</li> <li>• Level of Care determination, and re-determination, standards</li> </ul>	<ul style="list-style-type: none"> <li>• Quarterly report from LME on access outcomes for all new service requests.</li> <li>• Monthly review of eligibility by DMA.</li> <li>• Quarterly monitoring by state Accountability Team.</li> <li>• Annual Medicaid Compliance Audit by DMA.</li> </ul>	<ul style="list-style-type: none"> <li>• Corrective actions required based on report results.</li> <li>• Fair Hearing process for consumers.</li> <li>• Technical assistance from LME</li> </ul>
<b>Plan of Care</b>	Person Centered Planning and Service Delivery	<ul style="list-style-type: none"> <li>• Informed choice about providers</li> <li>• Discharge planning and service coordination</li> </ul>	<ul style="list-style-type: none"> <li>• \$ Allocations are based on historical data and prospective cost analyses</li> <li>• Person/Family-centered planning process</li> <li>• Standards for content and structure of plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Case manager oversees and monitors development, implementation, and cost of plan</li> <li>• Contact standards for case managers</li> <li>• LME monitors service costs across all consumers, using Utilization Review Tool</li> <li>• Monthly, quarterly, and annual monitoring reports</li> </ul>	<ul style="list-style-type: none"> <li>• Case manager assures plan changes are made in partnership with consumer/family</li> <li>• LME responsible for consumer satisfaction</li> </ul>
<b>Qualified Providers</b>	Provider Capacity and Capabilities	<ul style="list-style-type: none"> <li>• Use of institutional care</li> <li>• Community service network</li> </ul>	<ul style="list-style-type: none"> <li>• Licensure and Certification (DFS)</li> </ul>	<ul style="list-style-type: none"> <li>• LMEs monitor providers according to performance contract with state.</li> </ul>	<ul style="list-style-type: none"> <li>• LME refers monitoring findings to appropriate state agency for investigation and</li> </ul>

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<b>CMS Regional Review Protocol Categories</b>	<b>Related HCBS QF Domains</b>	<b>Key Measures</b>	<b>Design</b>	<b>Discovery</b>	<b>Remediation</b>
		profile <ul style="list-style-type: none"> <li>• Adherence to evidence-based best practices</li> <li>• Provider performance</li> </ul>	<ul style="list-style-type: none"> <li>• Provider criminal record checks</li> <li>• Provider standards (Provider enrollment process)</li> </ul>		action <ul style="list-style-type: none"> <li>• State and LME teams collaborate to analyze monitoring reports to ensure timely and appropriate correction of problems</li> <li>• State provides technical assistance to LME to support oversight.</li> </ul>
<b>Health and Welfare</b>	Participant Safeguards	<ul style="list-style-type: none"> <li>• Critical incidents</li> <li>• Medication management</li> <li>• Restrictive interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Disaster Preparedness, Response, and Recovery plan</li> <li>• Emergency Plans and supplies</li> <li>• Policies on seclusion and restraint</li> <li>• Incident Response System</li> <li>• Complaint and Appeals process</li> <li>• State-level Consumer Services and Consumer Rights (CSCR) team</li> <li>• Client Rights Committees</li> </ul>	<ul style="list-style-type: none"> <li>• Incident response hierarchy assures timely and appropriate processing of incident reports</li> <li>• CSCR team analyzes data on complaints on state level</li> <li>• Client Rights Committees review incidents and complaints at LME level</li> <li>• Mortality reviews by LMEs</li> </ul>	<ul style="list-style-type: none"> <li>• LME uses incident response data to develop monitoring schedules and interventions.</li> <li>• CSCR team reviews all higher level incidents for LME and provider responses</li> </ul>
<b>Administrative Authority</b>	<ul style="list-style-type: none"> <li>• Participant Outcomes</li> <li>• Participant Satisfaction</li> <li>• System Performance</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical outcomes</li> <li>• Personal outcomes</li> <li>• Community inclusion</li> <li>• Criminal justice involvement</li> <li>• Employment and school</li> <li>• Housing</li> <li>• Quality of life indicators</li> <li>• Satisfaction measures for Access, Appropriateness, Respect, Services and supports</li> <li>• Program financial integrity</li> <li>• Information system capabilities</li> <li>• Quality assurance monitoring</li> <li>• Utilization review</li> <li>• Quality improvement process</li> <li>• Participant and stakeholder involvement</li> </ul>	<ul style="list-style-type: none"> <li>• DMA Quality Assurance Program</li> <li>• Quality Management Plan</li> <li>• “Virtual Budget”, data-based allocation process</li> </ul>	<ul style="list-style-type: none"> <li>• Program data collected through MMIS and IPRS</li> <li>• Consumer data collected through CDW, DD-COI, and NCI.</li> <li>• Medicaid Compliance Audits</li> <li>• DMA Program Integrity Reviews</li> </ul>	<ul style="list-style-type: none"> <li>• Reports based on key indicators are shared with LMEs</li> <li>• Providers subject to paybacks and/or plans of correction for compliance audit findings</li> <li>• Program Integrity findings revealing fraud are referred to the Department of Justice.</li> </ul>

**Quality Management Plan - 1915 ( c ) Waiver**  
North Carolina Department of Health and Human Services  
Division of Mental Health, Developmental Disabilities and Substance Abuse Services  
**ATTACHMENT 1**

Domain	Desired Outcome	Item	Status	Suggested Reporting Frequency
Participant Access	Individuals have ready access to home and community-based services and supports in their communities.	Services received (units, \$)	Currently in use	Q
		Target populations served	Currently in use	Q
		Penetration rates	In development	Q
		<b>Timely access</b>	<b>In development</b>	<b>Q</b>
Person Centered Planning and Service Delivery	Services and supports are planned and implemented in accordance with each participant's needs, preferences and decisions about his/her life in the community.	<b>Discharge/after care planning and service coordination</b>	<b>Currently in use</b>	<b>A</b>
		<b>Informed choice about providers</b>	<b>In development</b>	<b>A</b>
Provider Capacity and Capabilities	There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.	<b>Utilization of state institutional care</b>	<b>Currently in use</b>	<b>Q</b>
		<b>Distribution &amp; types of community-based services</b>	<b>In development</b>	<b>Q</b>
		Provider performance	In development	
		Availability of and fidelity to best practice models	In development	
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.	<b>Critical incidents</b>	<b>Currently in use</b>	<b>Q</b>
		<b>Medication management</b>	<b>Currently in use</b>	<b>Q</b>
		<b>Restrictive interventions</b>	<b>Currently in use</b>	<b>Q</b>
Participant Rights and Responsibilities	Participants receive support to exercise their rights in accepting personal responsibilities.	<b>Rights information (service denial notifications)</b>	<b>Currently in use</b>	<b>A</b>
		<b>Complaints and appeals (# and types)</b>	<b>Currently in use</b>	<b>Q</b>
Participant Outcomes	Participants achieve desired outcomes.	Clinical outcomes, improved function	Currently in use	A
		Community inclusion	Currently in use	A
		Criminal justice/Juvenile Justice involvement	Currently in use	A
		Employment/school	Currently in use	A
		Housing (independence and safety)	Currently in use	A
		Personal goals outcomes	Currently in use	A
		Quality of life indicators, well-being	Currently in use	A
Participant Satisfaction (with system and processes)	Participants are satisfied with their services.	Access	Currently in use	A
		Appropriateness	Currently in use	A
		Respect/courtesy	Currently in use	A
		Services and supports	Currently in use	A
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.	<b>Financial integrity</b>	<b>Currently in use</b>	<b>Q</b>
		<b>Information systems and monitoring capabilities</b>	<b>Currently in use</b>	<b>Q</b>
		Quality Assurance process (audits and provider monitoring)	Currently in use	Q
		Utilization Management/Review (high costs, denials or adjustments)	Currently in use	Q
		Quality Improvement process (local)	In development	A
		<b>Participant and stakeholder involvement (CFAC)</b>	<b>In development</b>	<b>Q</b>
		Quality Improvement process (state)	In development	

Bold items are included in the LME Performance Contract (along with other measures)

Frequency = Q (quarterly), S (semi-annually) or A (annually)

**Quality Management Plan - 1915 ( c ) Waiver**  
North Carolina Department of Health and Human Services  
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

**ATTACHMENT 2**

<b>System</b>	<b>Purpose</b>	<b>Status for Waiver Participants</b>
Integrated Payment and Reporting System (IPRS)	Service utilization and claims data for state funds. The IPRS will be used to track, pay and report on claims submitted by providers for services rendered. Area programs/LME's will submit a single claim to the state, and the IPRS will process the claim from the appropriate funding source: Medicaid, Pioneer, CTSP and capitated risk contracts.	In use
Medicaid Management Information System (MMIS)	Service utilization and claims data for Medicaid funds	In use
(HEARTS) Healthcare Enterprise Accounts Receivable and Tracking System	Billing system used for state operated facilities. Service utilization and consumer descriptive and outcomes information for state operated facilities	Applies only to individuals in state institutions
Client Data Warehouse (CDW)	Consumer demographics and descriptive information	In use
Decision Support Information System (DSIS)	Integrated consumer data from other data sources	In development
Automated Incident System	Consumer-specific information on deaths, abuse, restrictive interventions, and other incidents	In development
National Core Indicators (NCI)	Consumer outcomes and satisfaction information	In use
Developmental Disabilities Consumer Outcomes Inventory (DD-COI)	Consumer outcomes and satisfaction information	In use (to be replaced by NC TOPPS)
Olmstead Outcomes	Consumer outcomes and satisfaction for Olmstead populations	In use
NC SNAP	Assessment tool for DD populations	In use
NC TOPPS	Web-based consumer outcomes and satisfaction information	In development
MMIS+	Integrated service utilization and claims data for state and Medicaid funds	Planned
Health Information System (HIS)	Integrated DHHS information system	Planned

## **Attachment I**

# **Elderhaus PACE Quality Assurance Performance Improvement Plan 2006 Draft**

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Marsha Fretwell, MD  
Medical Director

Date

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Carolyn Soders  
Chair, Elderhaus, Inc. Board of Directors

Date

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### **Introduction**

Elderhaus PACE, a startup PACE organization, is in the process of developing its Quality Assurance and Performance Improvement Plan. This document is the working draft of that Plan.

### **Purpose**

The Elderhaus PACE Quality Assurance and Performance Improvement (QAPI) Program is designed to support the mission, philosophy and goals of the organization. In order to maximize service, make improvements and minimize errors, Elderhaus PACE strives to:

1. Develop and support a therapeutic clinical environment to maximize every participant's capability;
2. Engage each member of the Interdisciplinary Team in the improvement process;
3. Promote open communication;
4. Progressively improve all services;
5. Encourage and promote innovation and creativity; and
6. Enhance services using input solicited from participants, caregivers, interested members of the community and Elderhaus PACE employees and contractors.

The Elderhaus PACE QAPI Program is based on the following principles:

1. Effective operation of Elderhaus PACE internal and external systems results from cooperative teamwork among participants, caregivers, families, interested members of the community and Elderhaus PACE employees and contractors.
2. The Interdisciplinary Team is the primary contributor to organizational effectiveness since it assesses each participant, develops and implements individualized plans of care, monitors participant progress, and modifies the participant plan of care as necessary.
3. The needs, preferences and values of internal and external customers identified by data from sources including the Participant Council, Consumer Advisory Council and review of grievances and appeals drive the quality goals of Elderhaus PACE.
4. QAPI education and training are integral parts of staff development activities.
5. All disciplines and contract providers are interdependent and share responsibility for evaluating and improving the quality of participant care and services.
6. All Elderhaus PACE providers will maintain the confidentiality of medical information, written and otherwise, and show respect for participants' beliefs, values, expectations, and attitudes about health, illness, health care, and quality of life.
7. To the extent possible, QAPI activities will use objective, quantifiable measures, statistically valid analysis techniques, and meaningful comparison data.
8. The QAPI Program will address all domains of service, including structure, process, and outcomes.

## **Goal**

The goal of the Elderhaus PACE QAPI program is to provide high quality, sustainable services. The improvement process considers the institutional context, describes desired performance, identifies gaps between desired and actual performance, identifies root causes, selects interventions to close the gaps and measures changes in performance (Reproline The Reading Room. (2003). Retrieved October 4, 2006, from [http://www.reproline.jhu.edu/english/6read/6pi/pi\\_what.htm](http://www.reproline.jhu.edu/english/6read/6pi/pi_what.htm)).

## **Objectives**

Specific objectives of the Elderhaus PACE QAPI Plan are to:

- Assure effective, timely and safe delivery of care
- Identify core and critical processes that most affect participant outcomes as a focus of process standardization and performance improvement.
- Ensure all team members, staff, and contract providers are involved in the development and implementation of the quality assessment and performance improvement activities and are aware of the results of these activities

## **Responsibilities**

The QAPI plan applies to all services provided by medical staff, employees, volunteers, contractors and others affiliated with Elderhaus PACE.

Responsibility for quality assessment and performance improvement ultimately rests with the organization's governing body, the Board of Directors for Elderhaus, Inc. This governing body has the final authority to commit adequate resources and create a culture to support QAPI efforts. The governing body will:

1. Activate the organization's mission by continually improving the quality of participant care and services;
2. Incorporate findings from quality assessment and improvement activities in strategic, program, and resource planning;
3. Provide guidance toward continuing education concerning the approach, methods, tools, and application of continuous quality improvement;
4. Establish broad guidelines for quality improvement activities in conjunction with the Elderhaus PACE Management Team;
5. Guide process analysis and improvement;
6. Provide for and review an annual evaluation of the performance of the Elderhaus PACE QAPI Program.

The Elderhaus PACE *Management Team* (see below) provides oversight of all Elderhaus PACE QAPI activities. The Elderhaus PACE *Quality Improvement Coordinator* will be responsible for ensuring that quality data are collected from all appropriate sources, that the data are examined and that results are shared with all appropriate staff and/or committee members for follow-up action. The Quality Improvement Coordinator will produce an annual Quality Management Summary (QMS) to be reviewed with the Management Team and passed up to the Elderhaus PACE Board of Directors.

## **Committees**

### *Management Team*

#### Purpose

The Elderhaus PACE Management Team provides oversight for the overall administrative and clinical operations of the organization. The Management Team may create new committees or

task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff.

#### Monthly Review:

- all QAPI Plan initiatives
- results of monitoring activities
- proposed changes to improve quality of service
- review follow-up of all changes implemented
- all utilization information for all Elderhaus PACE sites.

#### Membership

Elderhaus PACE CEO, Medical Director, PACE Program Director/CFO, Center Manager, Marketing and Planning Coordinator, Quality Improvement Coordinator, and Intake Coordinator.

#### Structure

The Management Team will meet monthly (for a minimum of 11 months/year) to review performance indicators, results of monitoring activities, death and disenrollment information and utilization information. The Elderhaus PACE Program Director facilitates Management Team meetings and will request Action Plans from contracted providers as a part of grievance investigations or other monitoring activities. Contracted providers will receive on-site visits as necessary. The Management Team reports to the Elderhaus PACE Board of Directors through the CEO or the Elderhaus PACE Program Director.

#### *Quality Improvement Committee*

#### Purpose

The committee, with its interdisciplinary team representation, ensures an individualized approach to the QAPI process.

#### Membership

Membership consists a member from each discipline of the interdisciplinary team. The Quality Improvement Coordinator serves as the chair of the committee.

#### Structure

Meetings will be held on a monthly basis. The committee will develop at least 2 indicators during the year which combine priorities established by Management Team with opportunities for improvement identified at the site. Indicators will continue to be tracked until acceptable performance levels are achieved and periodically thereafter to confirm sustained improvement. All data will be generated through the committee. Findings will be reported to the Management Team on a monthly basis. Appendix A contains the committee report format.

#### *Focused Review Committee*

#### Purpose

Administrative staff routinely review key performance elements including (but not limited to)

deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization as part of ongoing operations. CMS requires monitoring data for routine immunizations, grievances and appeals, enrollments, disenrollments, prospective enrollments, unscheduled hospitalizations, emergent (unscheduled) care, deaths, sentinel events and unusual occurrences involving participants, staff or volunteers. If the Management Team identifies problems related to any of these indicators, a more expanded focused review may be initiated by referral to this committee.

#### Membership

Membership will be flexible based on those with knowledge of the specific issues being addressed, but will include at least two of the following positions and/or functions: Medical Director, Quality Improvement Coordinator, Elderhaus PACE Program Director/Chief Financial Officer, or Clinical Pharmacist. The Committee will be chaired by the Medical Director, who will report on activities and results to Management Team.

#### Structure

The Committee will meet *as needed* to review those critical indicators assigned to them by the Management Team. The committee shall submit written Quality Management/Quality Indicator reports through the Management Team to the Elderhaus PACE Board of Directors summarizing its work and recommendations. This Committee will also be responsible for managing all peer review activities, performed by independent reviewers, related to adverse outcomes.

#### *Medical Advisory Committee*

##### Purpose

This committee is responsible for oversight of all clinical operations of the program and for providing input on standards of medical care in the catchment community. In addition, members provide guidance in the development and implementation of medical policies and procedures for Elderhaus PACE and in the selection of medical specialists under contracted arrangements with Elderhaus PACE.

##### Membership

Members include community physicians, the Elderhaus PACE Program Director, Elderhaus PACE Medical Director, and Elderhaus PACE Primary Care Staff.

##### Structure

The committee meets on a quarterly basis and reports to the Elderhaus PACE Board of Directors via the Elderhaus PACE Medical Director.

#### *Consumer Advisory Council*

##### Purpose

The Consumer Advisory Council provides advice to the governing board on issues related to participant care concerns and program operations from a community perspective.

### Membership

The Consumer Advisory Council members are representatives of participants, participants' families, and communities from which participants are referred. The Elderhaus PACE Marketing and Planning Coordinator facilitates council meetings.

### Structure

The Council meets quarterly. The Council facilitator forward meeting minutes to the Consumer Advisory Council members and the Elderhaus PACE Program Director who keeps minutes on file.

### *Ethics Committee*

### Purpose

The Ethics Committee advises Elderhaus PACE staff on individual participant matters involving ethical dilemmas encountered by the staff during provision of care to participants and their caregivers. The committee may also serve as a consultative resource in grievance issues raised by Elderhaus PACE participants and their families. The committee advises the program on policy development related to ethical decision making, including policies related to the determination of healthcare wishes and resuscitation.

### Membership

The Ethics Committee membership includes representatives of the Elderhaus PACE staff, the local medical, legal, and religious communities, as well as community service agencies.

### Structure

The committee meets every other month, as needed, and reports through the Medical Director and the Management Team to the Board of Directors. Minutes are kept on file. The minutes format is in Appendix A.

## **Performance Goals or Benchmarks**

Selecting appropriate measures is a key to a successful QAPI plan. Priority measures in the Elderhaus PACE QAPI Plan will be:

1. indicators which assess technical skill and professional judgment, or measure key functions
2. processes that affect participant care
3. key activities identified as high risk, high volume and/or problem prone areas.

Outcome measures can either measure an end-result outcome or an instrumental outcome. An end-result outcome is a change in a participant or caregiver status in an area that care is, or should be, intended to directly impact. An instrumental outcome is an area of care which is a “facilitating” outcome that may be important in attaining an end-result outcome, although it is not the primary focus of care. Each measure selected will be evaluated on the basis of its being objective, measurable, and based on current knowledge and clinical experience.

### Nutritional Services

Elderhaus PACE will complete an initial nutrition assessment at each participant admission and a reassessment every six months thereafter. Nutritional risk, weight change, and other nutritional status criteria will be evaluated. Monthly (or more frequent) measurement of each participant's weight will be appropriately documented in the participant medical record. Weight changes may enable early identification of participants at high risk for nutritional issues. Results from nutritional interventions documented in the participant care plan will be analyzed and evaluated quarterly and annually for improvement of outcomes .

### End of Life

Elderhaus PACE will monitor which participants have signed advance directives and will assist participants and their families/caregivers to execute advance directives and/or *health care powers of attorney*, if necessary. Health care wishes will be discussed upon enrollment of new participants, reviewed as part of the emergency care plan with each reassessment, and readdressed as appropriate.

### Home Environment/Home Care

Elderhaus PACE will conduct an initial assessment and at least an annual reassessment of each participant's home environment. The assessment may include identifying structural barriers that limit mobility, safety hazards (including fall risks), sanitation hazards and assistive devices that are present or needed in the home. Recommendations for correction of hazards, addition of equipment, or other counsel will be implemented as approved by the Interdisciplinary Team. QAPI will particularly track the *number of homecare service units being used* and the *adequacy of homecare services*.

### Social Work

Social work staff will complete an assessment upon initial enrollment and at least every six months. The Interdisciplinary Team, with data gathered by Social Work staff, will particularly look for changes in *self-reported health status*, *satisfaction with care*, and *caregiver quality of life*.

### Service Utilization

Elderhaus PACE will collect data on hospitalizations, emergency medicine visits, nursing home placements, rehabilitation services, psychiatric services, day health center services, in-home services, and outpatient medical services. The Elderhaus PACE Program Director will track monthly utilization information. Data will be forwarded to Elderhaus PACE Administration for data entry and reported in quarterly QAPI summaries. These summaries will continue to be shared with the Elderhaus PACE Board, Management Team, and the Quality Improvement Committee. Elderhaus PACE utilization data will be compared with other PACE programs as such comparison data is available.

### Caregiver and Participant Satisfaction

Elderhaus PACE will survey participants with each assessment and reassessment (see Social Work above) to evaluate their satisfaction with the program. Efforts will be made to reliably survey participants with cognitive impairments. Family members of participants also will be given regular opportunities to express their opinions and suggestions about the program through

representatives to the Consumer Advisory Council (see above), through the collection of information on *caregiver quality of life* (see Social Work above), through the grievance/appeals process, and through responses to written surveys (e.g. Health Outcomes Surveys). Another more informal method of assessing satisfaction is the monthly Participant Council meeting (minutes recorded, including resolution of problematic issues raised).

#### Clinical Data Outcome Measures

Data will be collected during initial and periodic assessments that will enable outcome measures. The measures will include, at minimum, the following:

- Physiological and clinical well-being: data about clinical conditions for which direct or indirect measures are readily available and easy to accurately collect. Examples include data on specific disease management protocols, *fall risk*, medication usage, immunizations, presence and healing or progression of *pressure sores* and *restraint usage*. Data collection will be at admission and at six-month reassessment at a minimum.
- Functional status: data denoting ability to carry out basic activities of daily living: *bathing, dressing, grooming, toileting, transferring, walking, and feeding*. Data collection will be at admission and at six-month reassessment at a minimum.
- Cognitive functioning: data consist of scored measures of cognitive functioning such as the *Mental Status Questionnaire (MSQ)* or the *Folstein Mini Mental State Inventory*. Data collection will be at admission and at six-month reassessment at a minimum.
- Emotional/mental health status: data consist of scores on the *Geriatric Depression Scale* collected at least annually. Mood, anxiety, depression, behavior problems, wandering and suspicion of abuse will be assessed when appropriate.
- Effectiveness staff-provided and contract-provided services: data consist of documentation in the medical record related to participants' ability to achieve treatment goals at reassessment review by the Interdisciplinary Team.
- Safety of staff-provided and contract-provided services: data consist of day-to-day observations of staff performance by supervisory personnel, staff performance on periodic competency verification or regulatory review of staff performance.
- Non-clinical area monitoring
  - Grievances: Grievances will be forwarded to the Quality Improvement Coordinator for tracking and trending. The QI Coordinator will report results of grievances to the Management Team for direction on how appropriate staff and/or Committees should implement corrective action.
  - Appeals: Appeals will be forwarded to the Elderhaus PACE Program Director for review and decision implementation. The Director will share appeal outcomes with the Interdisciplinary Team which will inform caregivers and participants of decisions and assist them as needed.
  - Transportation services: will be monitored by monthly surveys and grievance trending and reported via quarterly QAPI summaries (dissemination process above).
  - Meal quality: will be monitored through daily checks of food temperatures as well as comments solicited in monthly Participant Council meetings and trending of grievances about food quality as recorded in centers' grievance logs.

- Life safety: will be monitored internally by quarterly fire drills and at least annual mock code and mock disaster drills as well as regulatory agency inspections.
- internal environment: will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise (maintenance reporting and repair logs used).

Plans of correction on problems noted will be implemented by center staff and reviewed by the Director and the Quality Improvement Coordinator.

## **QAPI Implementation**

Key to implementing the QAPI plan is having a system in place to regularly and systematically collect, record and report data.

- Selected aggregated outcomes data will be reviewed for trends, patterns and opportunities for improvement.
- Variation in outcomes will be evaluated from both the program and the individual participant perspective.
- When practice variations are identified, a plan will be developed and implemented to identify more effective practices whenever possible.
- The QAPI plan will use standard data measures developed by such organizations as the National PACE Association whenever possible and those specified by CMS and the State administering agency as specified (in accordance with §460.140). Professional standards of Elderhaus PACE staff will be measured against those outlined by their respective licensing agency in the state of North Carolina (e.g. the North Carolina Board of Nursing). When published guidelines do not appropriately address the Elderhaus PACE population, internal standards inferred by available data may be developed.
- The Elderhaus PACE Management Team will identify both problems and areas of outstanding performance.
- The organization will monitor staff and contractors to ensure appropriate standards of care are met and appropriate training and credentialing are maintained. Service delivery will be monitored through feedback from staff, participants, and family members during daily staff meetings, care plan reviews, and meetings with families.
- The organization will monitor performance in non-clinical areas. Examples include problems identified during fire drills or problems with timeliness of transportation. All participants will be educated about the grievance process and grievances will be monitored for opportunities to improve future performance.
- Enrollment and disenrollment data, particularly reasons for disenrollment, will be reviewed at least quarterly and compared with benchmarks set against other PACE programs.
- Monitoring of Occurrences. Review of occurrence reports will be used to monitor possible problems with safe practice, maintaining a safe environment, or protecting participants' rights. Occurrence reports may result from:
  - Abuse or suspected abuse
  - Participant elopement
  - An outbreak of a communicable disease

- Occurrences involving police or fire department
- Theft or vandalism of property at Elderhaus PACE or at contract providers working with Elderhaus PACE
- Falls
- Accidents
- Potential for injury
- Medication administration errors or medication adverse reactions
- Other unusual occurrences
- Prevention of Fraud, Waste, and Abuse: Elderhaus PACE will participate in the NPA sponsored evaluation and procedure development being implemented to address monitoring and audit requirements under the new Part-D Medicare regulations. As findings and tools become available, they will be incorporated into the QAPI process.
- Data Integrity: Elderhaus PACE will monitor its data collection processes for timeliness, completeness, and accuracy. Tracking and trending may identify problems with data as may periodic spots checks. Identified problems with data collection will be treated as opportunities to improve performance.

## **Improvement Process**

Corrective actions and outcomes resulting in best practices will be incorporated into Elderhaus PACE policies and procedures.

- Role of the QI Coordinator. The QI Coordinator is responsible for assuring that the data collected and reported are accurate, timely and complete. The QI Coordinator will assist in performing the appropriate statistical analyses to assure consistency and ease of presentation and review. The QI Coordinator will assist in detecting trends, patterns, and opportunities for improvements as well as potential problems. In addition, the QIC, along with the Intake Coordinator and the Center Manager, submit monthly data to data entry personnel both in manual and electronic format on data collection tools such as the “Inpatient and Emergency Services Utilization” form completed by the Center Manager. Elderhaus PACE data entry personnel enter HPMS PACE data electronically no less frequently than quarterly.
- Peer review for clinical staff. Peer review will be conducted under the direction of senior staff. Interdisciplinary team members will not be responsible for reviewing care for which he/she is responsible. When only one discipline representative is on staff, practice will be reviewed within the expertise of the department. In cases where there is no individual with expertise in that field in the organization, provisions will be made to have care evaluated by an outside expert in the discipline.
- Review for non-clinical staff. When outcomes involve non-clinical staff, review will be conducted under the supervision of appropriate supervisory staff. Outcomes identified through quality management projects will be reevaluated as needed to determine if corrective steps improved outcomes.
- Corrective Action Plans. When opportunities for improvement are identified, a corrective plan will be created. Each corrective plan will include: an explanation of the problem, who is responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness. The

Management Team will develop Corrective Action Plans related to global problems, implement those plans, and evaluate their effectiveness. Corrective Action Plans from contracted providers will be requested by the QIC or other member of Management Team, as appropriate. Internal Action Plans will also be generated by the QI Committee and documented via committee minutes.

- **Priority Setting.** The Management Team, in consultation with the Elderhaus PACE Program Director, QI Coordinator, staff and participants, determines priorities for performance improvement at least annually. Priority will be based on severity, frequency, prevalence, and relevance to outcomes and feasibility of implementation. Priorities are communicated to the Board of Directors for approval.
- **Urgent Corrective Measures.** Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the Elderhaus PACE Director. The appropriate staff and the QI Coordinator will consult with relevant Elderhaus PACE staff and be responsible for developing an appropriate corrective plan within 24 hours. Urgent corrective measures will be discussed during morning meeting and, when appropriate, with participants. Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, or other actions will be implemented immediately. The QAPI plan and relevant policies and procedures will be amended to ensure the health and safety issues identified have been addressed.
- **Orientation of Staff and Contract Providers.** All new staff members are introduced to the QAPI plan and QAPI concepts during their orientation. Results of QAPI-identified benchmarks are shared with staff annually. Staff may be surveyed for new areas of improvement and reminded that they can bring issues to the Quality Improvement Committee or Management Team annually.
- **Orientation of New Elderhaus PACE Participants and their Families.** New Elderhaus PACE participants and their families are informed during the enrollment process of participants' rights, protection of health information, the grievance and appeals processes, and other methods of voicing satisfaction or dissatisfaction with program services. They are encouraged to give both positive and negative feedback to program staff.

## **Re-Evaluation and Follow-up**

Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:

1. Severity of the problem
2. Frequency of occurrence
3. Impact of the problem on participant outcomes
4. Feasibility of implementation

If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement. A schedule for re-evaluation will be developed and will be updated with the Management Team. If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of

the source of variation are needed. A subcommittee of the Management Team or other workgroup may be established to address specific problems. All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

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last updated: 4 October 2006

## Attachment J

### NORTH CAROLINA RISK ISSUE IDENTIFICATION TOOL

<b>Name of Individual:</b>	<b>Date Completed:</b>
<b>Individual's Support Coordination Agency:</b>	
<b>Name of Person Completing This Form &amp; and Relationship to the Individual</b>	

#### I. Identify Risk Issues

<b>Situational</b> (situations, systemic issues, mental health issues, or circumstances with caregivers, family, friends, or others that create the potential for risk)			
✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Loss of caregiver or close family member		
	Loss of someone significant		
	Loss of natural supports		
	Social isolation by caregiver		
	Refusal of critical services (by the individual or the guardian)		
	Unavailable or unreliable staffing		
	Significantly compromised hygiene or appearance (especially if a change from usual)		
	Incapacitated caregiver		
	History of abuse or neglect		
	Pregnancy and parenthood		
	Compromised communication skills		
	Loss of home		
	Eviction		
	Frequent moves for seemingly unjustified reasons		
	Difficulties with relationship with landlord		
	Dangerous or threatening neighbors		

<b>Environmental</b> (environmental issues that create the potential for risk)			
✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Unsanitary living conditions		
	Home is in significant disrepair		
	Necessary environmental modifications not completed		
	Necessary equipment in disrepair, broken, or is lost		
	Unmet equipment needs		
	Equipment not being available for use		

<b>Behavioral</b> (personal behaviors or lifestyle choices that are considered dangerous or potentially dangerous to self or pose a risk to others)			
✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years

**Behavioral** (personal behaviors or lifestyle choices that are considered dangerous or potentially dangerous to self or pose a risk to others)

✓	Risk Issue	Why is this issue of particular risk to this person?	
	Self injury		
	Aggression or violence towards others		
		Current	Within five (5) Years
	Assault		
	Stealing		
	Excessive self-stimulatory behaviors		
	Making significant threats to the safety of others		
	Destruction of property		
	Refusal of necessary services		
	Poor compliance with treatments or supports		
	Elopement		
	Social isolation		
	Compromised communication skills		
	History of poor decision making despite being well-informed		
	Risky sexual behaviors		
	Predatory behavior		
	Excessive fascination with children or sexual abuse of children		
	History of sexually aggressive or dangerous behaviors		
	Fascination with fire or history of fire setting		
	Frequent job changes		
	Suicidal ideation or attempt		
	Substance abuse		
	Contacts with EMS or law enforcement (i.e. unnecessary calls to or create situations to cause others to call)		
	Criminal justice involvement		
	Multiple requests for crisis services		

**Medical** (health-related risks)

✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Multiple medical or psychiatric hospitalizations in a year		
	Multiple visits to the emergency room (whether admitted or not)		
	A person living alone or with little support who takes multiple medications		
	Taking three or more medications for a chronic medical condition, including a psychiatric diagnosis with reduced supports		
	Medical benefit loss		
	Poor follow through on post hospitalization discharge orders		
	Significant change in health or mental status		
	Significant changes in sleeping or eating patterns		
	Significant number of medical visits or a significant		

Medical (health-related risks)			
✓	Risk Issue	Why is this issue of particular risk to this person?	
	increase in medical visits		
	Unmet medical needs (i.e. appointments not scheduled, follow-up appointments missed)		
		Current	Within five (5) Years
	Information shared with medical personnel by support staff is inadequate (i.e. reason for referral)		
	Poor compliance or non-compliance with medical regime		
	Refusal of services		
	Inability to tolerate a medical examination/procedure		
	Multiple falls/fractures		
	Mobility impairment		
	Significant weight gain or loss		
	Swallowing disorders		
	History of choking and/or aspiration		
	Skin breakdown		
	Obesity		
	Compromised communication skills (especially in relation to being able to indicate physical pain)		
	Pica		
	Lifestyle choices that negatively affect health (i.e. smoking, drinking when contraindicated by medications)		

Financial risks (mismanagement of finances by self or others or loss of income)			
✓	Risk Issue	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years
	Loss of job		
	Loss of benefits or significant reduction in benefits		
	Indebtedness		
	Loaning money to others		
	Excessive gambling		
	Financial exploitation		
	Excessive housing costs		

Other risks (identified risks not otherwise mentioned above)			
✓	What is the Issue?	Why is this issue of particular risk to this person?	
		Current	Within five (5) Years

## II. Summary of Incident Reports

<b>Reportable Incidents</b> (summarize by type of incident, the number of reportable incidents, or attach other printout summary of reportable incidents)
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## Attachment K

Qualified Residences for North Carolina Money Follows the Person Participants				
Type of Qualified Residence	Number of Each Type of Qualified Residences*	State of Definition Housing Settings & Number of Each	Number of Each Settings*	How Regulated
Home owned or leased by individual's family member		<ul style="list-style-type: none"> <li>• Home leased by individual or family</li> <li>• Home owned by individual</li> <li>• Home owned by family</li> </ul>		<ul style="list-style-type: none"> <li>• Lease with landlord</li> <li>• N/A</li> <li>• N/A</li> </ul>
Apartment with an individual lease, lockable access & egress, & which includes living, sleeping, bathing, & cooking areas over which the individual or the individual's family has domain & control.		<ul style="list-style-type: none"> <li>• Apartment building</li> <li>• Assisted living: multi-unit assisted housing with services</li> <li>• Public housing units</li> <li>• Rural Development Apartment</li> <li>• Housing Credit unit</li> <li>• Supportive housing unit</li> </ul>		<ul style="list-style-type: none"> <li>• Lease with private landlord</li> <li>• Lease with private landlord and HC Voucher</li> <li>• Lease with Public Housing Agency</li> <li>• Lease with RD</li> <li>• Lease with landlord w/HC Voucher</li> <li>• Lease with landlord and Key assistance</li> <li>• Lease with landlord</li> </ul>
Residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside (Non-Intermediate Care Facility-Mental Retardation facility).		<ul style="list-style-type: none"> <li>• Supervised Living</li> <li>• Alternative Family Living</li> <li>• Family Care Home</li> </ul>		<ul style="list-style-type: none"> <li>• State122C licensing regulations</li> <li>• 131D licensing regulations</li> </ul>

**\*To be determined as individuals are transitioned**

## Attachment L

L I N D A M . H I C K S

4325 Whisperwood Drive  
Raleigh, North Carolina 27616  
919-412-4310  
lindamhicks@gmail.com

### EXPERIENCE

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March 25, 2008 – present      Dept. of Health and Human Services      Raleigh, NC

#### *Project Director*

- Manage Money Follows the Person demonstration grant for the state of North Carolina.

May 15, 2005 – March 21, 2008      Durham's Partnership for Children      Durham, NC  
*More at Four Program Manager*

- Coordinated all aspects of More at Four (MAF) program in Durham county.
- Monitored compliance to State and local MAF Guidelines and Requirements.
- Coordinated collaborative efforts with community agencies serving children and families which have an impact on MAF program (health agencies, family support agencies, local Head Start grantee, etc.).
- Coordinated training and technical assistance.
- Supervised staff of two fulltime employees, social work intern (when applicable), temporary employees, and contract personnel.
- Strategic planning for MAF program, county pre-kindergarten programs, and the organization based on results of evaluations and needs assessments.

May 2001 – May 2005      East Coast Migrant Head Start Project      Raleigh, NC  
*Program Monitor*

- Monitored Delegate Agencies and Direct Service programs in adherence to the Head Start Performance Standards and contract compliance (Delegate Agencies).
- Strategic planning for organization based on monitoring results, evaluations, and needs assessments (conducted annually).
- Provided training and technical assistance for program self-assessment, monitoring systems, and development of department manuals, policies and procedures.
- Assisted in the design and content of the departmental Monitoring manual.

50% travel along the East Coast of USA.

Sept. 1999– April 2001      Wake County Smart Start      Raleigh, NC  
*Quality Enhancement Specialist*

- Provided early childhood technical assistance to childcare programs in Wake

County.

- Coordinated quarterly childcare conferences hosted by agency; led workshops.
- Evaluated programs using the ITERS and ECERS.

#### EDUCATION

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- |                     |                                  |                |
|---------------------|----------------------------------|----------------|
| 1979–1983           | University of Montevallo         | Montevallo, AL |
| ■                   | B.S., Early Childhood Education. |                |
| 2002 – October 2003 | University of Phoenix, Online    | Phoenix, AR    |
| ■                   | M.A., Organizational Management. |                |

#### ACCOMPLISHMENTS, OTHER

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Obtained NAEYC accreditation while at Washington St. United Methodist Church Child Development Center (1995)

Obtained CITA accreditation for Garner, NC center while at Sylvan Learning Center (1999)

Trained trainer in the TouchPoints model (T. Berry Brazelton, MD) (2000)

Environmental Rating Scales (ECERS, ITERS) training—3-day course (2001)

Office of Head Start PRISM Reviewer (2002 –present)

Facilitator—Wake Education Summit (2004); Durham Public Education Network (2007) and various community functions related to position at Durham’s Partnership for Children

Trained trainer (2 day course)—Foundations: NC Early Learning Standards (2006)

## **A t t a c h m e n t   M**

### **TITLE:**

Money Follows the Person Program Specialist

### **SCOPE OF WORK:**

To analyze and interpret data, assess federal and state regulations, rules and provider contracts, for use in developing and managing the Money Follows the Person (MFP) project's strategic plan.

### **ACCOUNTABILITIES:**

Manage the Money Follows the Person (MFP) project strategic plan and assist with project management.

Serve as the liaison to the local and state agency's Transition Coordinators.

Research, develop and draft protocols and outreach materials, including the person-centered-planning process, for the Transition Coordinators.

Coordinate education, outreach and training activities for staff, other agencies, advisory councils and community providers.

Make formal presentations to appropriate state bureaus, nursing facilities, community agencies, advisory and planning councils to build strong collaborations, to implement and improve policies and protocols.

Analyze and interpret reports from Transition Coordinators and other relevant reports; make recommendations for improvement to the Project Director.

Consult with associated groups and agencies to ensure coordination in the development and implementation of the project's strategic plan.

Provide information to nursing facilities regarding the goals and expectations of the project.

Produce regular reports as required by the MFP grant and the Project Director.

Perform other duties as required by the Project Director.

### **MINIMUM QUALIFICATIONS**

Education: Bachelor's degree from a recognized college or university with a major study in a field relevant to adults with disabilities. Each additional year of approved formal education may be substituted for one year of required work experience.

Experience: Four years' professional or paraprofessional experience in a field or occupation relevant to services provided by and protocols in the Department of Health and Human Services, Division of Medical Assistance with responsibility for program implementation, direct service delivery, planning or program evaluation. Each additional year of approved work experience may be substituted for one year of required formal education.

License/Certification: Valid driver's license and/or access to transportation for use in statewide travel.

DISCLAIMER STATEMENT: The job description lists the essential functions of the position and is not intended to include every job duty and responsibility specific to the position. An employee may be required to perform other related duties not listed on the supplemental job description provided that such duties are characteristic of that classification.

SIGNATURES: I have reviewed this job description for content.

Reviewer's Name, Title & Position #: \_\_\_\_\_, # \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Reviewer's Signature  
Reviewed

\_\_\_\_\_  
Date

I have reviewed the content of the above job description with my supervisor.

\_\_\_\_\_

\_\_\_\_\_  
Employee's Name and Signature

\_\_\_\_\_  
Date

## Attachment N

North Carolina Money Follows the Person Rebalancing Demonstration Preliminary Budget						
Demonstration Personnel						
	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	TOTAL
Project Director	\$57,979	\$59,428	\$60,914	\$62,437	\$63,998	304,756
Program Specialist	\$57,979	\$59,428	\$60,914	\$62,437	\$63,998	304,756
Admin Assistant	\$26,825	\$27,496	\$28,183	\$28,888	\$29,610	141,002
Fringe Benefits	\$26,415	\$27,075	\$27,752	\$28,446	\$29,157	138,845
TOTAL	\$169,198	\$173,427	\$177,763	\$182,208	\$186,763	\$889,359
Other Administrative						
MMIS Configuration	\$1,000,000					\$1,000,000
Total Administrative						
						\$1,889,359

**MFP DEMONSTRATION GRANT SUPPLEMENTAL BUDGET REQUEST INFORMATION**  
**STATE NAME:** North Carolina      **AWARD NO. (Grant#):** 1LICM0030170

**Attachment N1**

SECTION A - BUDGET SUMMARY						
Grant Program: MFP Demonstration (a)	Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	State Match (d)	Federal (e)	State Match (f)	Total (g)
CY 2007 AWARD	\$ 16,055.00	\$ 13,206.84	\$ 2,848.16			\$16,055
CY 2008 REQUEST	\$ 7,972,873.44			\$13,635,512	\$ (5,662,638.42)	\$7,972,873
<b>Total</b>	<b>\$ 7,988,928.44</b>					<b>\$7,988,928</b>
SECTION B - BUDGET CATEGORIES						
Object Class Categories		(1)	(2)	CY 08 Federal Funds (3)	CY 08 State Match Funds (4)	Total (5)
a. Personnel				\$303,866	\$303,866	\$607,731
b. Fringe Benefits				\$56,215	\$56,215	\$112,430
c. Travel						
d. Equipment						
e. Supplies						
f. Contractual				\$0	\$0	\$0
g. Construction						
h. Service Dollars				\$0	\$0	\$0
i. Total Direct Charges (sum of a-h)						\$0
j. Indirect Charges (MMIS Configuration)				\$1,330,969	\$287,034	\$1,618,003
k. TOTALS (sum of i and j)				\$1,691,050	\$647,115	\$2,338,164

0.82%

Special note: The total amount of the grant reward was adjusted by 52% (\$16,610,153.00) due to the reduction of CAP/MRDD clients who are going to be transitioned.

**NC Money Follows the Person Demonstration  
Worksheet for Proposed Budget  
Attachment N2**

<b>State/Grantee:</b>
<b>North Carolina</b>
<b>Grant #:</b>
<b>1LICMS030170</b>
<b>Demonstration Program Title:</b>
<b>Money Follows the Person</b>

Please express FMAP as a decimal. (example: 68.32%=.6832)

**State FMAP**

FFY 2007	0.6452
FFY 2008	0.6405
FFY 2009	0.6405
FFY 2010	0.6405
FFY 2011	0.6405

**Enhanced FMAP**

0.8226
0.82025
0.82025
0.82025
0.82025

**Populations to be Transitioned (unduplicated count)**

*Unduplicated Count* - Each individual is only counted once in the year that they physically transition.

All population counts and budget estimates are based on the Calendar Year (CY).

	<b>Elderly</b>	<b>MR/DD</b>	<b>Physically Disabled</b>	<b>Mental Illness</b>	<b>Dual Diagnosis</b>
CY 2007	0	0	0	0	0
CY 2008	1	2	8	0	0
CY 2009	5	9	51	0	0
CY 2010	7	15	61	0	0
CY 2011	9	12	82	0	0
Total Count	22	38	202	0	0
				<b>Total of Populations</b>	262

### **Demonstration Budget**

*Qualified HCBS Services, Demonstration HCBS Services and Supplemental Services* are defined in the RFP.

*Administration - Normal* - costs that adhere to CFR Title 42, Section 433(b)(7); *Administrative - 75%* - costs that adhere to CFR Title 42, Sections 433(b)(4) and 433(b)(10);

*Administrative - 90%* - costs that adhere to CFR Title 42 Section 433(b)(3)

*Federal Evaluation Supports* - costs related to administering the Quality of Life Survey (reimbursed @ \$100 per survey).

*Rebalancing Fund* is a calculation devised by CMS to estimate the amount of State savings attributed to the *Enhanced FMAP Rate* that could be reinvested into rebalancing benchmarks.

*Other* - Other costs reimbursed at a flat rate (to be determined by CMS)

<b>Total Expenditures (2007 - 2011)</b>	<b>Rate</b>	<b>Total Costs</b>	<b>Federal</b>	<b>State</b>
Qualified HCBS		\$ 7,972,874.00	\$ 6,539,749.90	\$ 1,433,124.10
Demonstration HCBS		\$ 1,823,000.00	\$ 1,495,315.75	\$ 327,684.25
Supplemental		\$ 1,097,931.00	\$ 703,224.81	\$ 394,706.19
Administrative - Normal		\$ 613,382.00	\$ 306,691.00	\$ 306,691.00
Administrative - 75%		\$ 1,618,003.00	\$ 1,213,502.25	\$ 404,500.75
Administrative - 90%		\$ -	\$ -	\$ -
Federal Evaluation Supports		\$ -	\$ -	\$ -
Other		\$ -	\$ -	\$ -
State Evaluation		\$ -	\$ -	\$ -
<b>Total</b>		\$ 13,125,190.00	\$ 10,258,483.70	\$ 2,866,706.30

Per Capita Service Costs	41579.4084
Per Capita Admin Costs	8516.73664
Rebalancing Fund	639857.048

<b>CY 2007</b>	<b>Rate</b>	<b>Total Costs</b>	<b>Federal</b>	<b>State</b>	<b>Summary</b>	
Qualified HCBS	0.8226		\$ -	\$ -	Actual Grant Award for CY	16055
Demonstration HCBS	0.8226		\$ -	\$ -	Total Fed Costs	16055
Supplemental	0.6452		\$ -	\$ -	Balance	0
Administrative - Normal	0.5	\$ 32,110.00	\$ 16,055.00	\$ 16,055.00	Award Request for next year	16055
Administrative - 75%	0.75		\$ -	\$ -	Total (Balance + Request)	16055
Administrative - 90%	0.9		\$ -	\$ -		
Federal Evaluation Supports	1		\$ -	\$ -		
Other	1		\$ -	\$ -		
State Evaluation (if approved)	0.5		\$ -	\$ -		
<b>Total</b>		\$ 32,110.00	\$ 16,055.00	\$ 16,055.00		

<b>CY 2008</b>	<b>Rate</b>	<b>Total Costs</b>	<b>Federal</b>	<b>State</b>	<b>Summary</b>	
Qualified HCBS	0.82025	\$ -	\$ -	\$ -	Actual Grant Award for CY	
Demonstration HCBS	0.82025	\$ 13,500.00	\$ 11,073.38	\$ 2,426.63	Total Fed Costs	1317176.354
Supplemental	0.6405	\$ 39,297.00	\$ 25,169.73	\$ 14,127.27	Balance	-1317176.354
Administrative - Normal	0.5	\$ 134,862.00	\$ 67,431.00	\$ 67,431.00	Award Request for next year	962524.47
Administrative - 75%	0.75	\$ 1,618,003.00	\$ 1,213,502.25	\$ 404,500.75	Total (Balance + Request)	-354651.8835
Administrative - 90%	0.9		\$ -	\$ -		
Federal Evaluation Supports	1		\$ -	\$ -		
Other	1		\$ -	\$ -		
State Evaluation (if approved)	0.5		\$ -	\$ -		
<b>Total</b>		\$ 1,805,662.00	\$ 1,317,176.35	\$ 488,485.65		

<b>CY 2009</b>	<b>Rate</b>	<b>Total Costs</b>	<b>Federal</b>	<b>State</b>	<b>Summary</b>	
Qualified HCBS	0.82025	\$ 1,727,456	\$ 1,416,945.78	\$ 310,510.22	Actual Grant Award for CY	
Demonstration HCBS	0.82025	\$ 321,000.00	\$ 263,300.25	\$ 57,699.75	Total Fed Costs	1866747.814
Supplemental	0.6405	\$ 180,639.00	\$ 115,699.28	\$ 64,939.72	Balance	-1866747.814
Administrative - Normal	0.5	\$ 141,605.00	\$ 70,802.50	\$ 70,802.50	Award Request for next year	2449404.07
Administrative - 75%	0.75		\$ -	\$ -	Total (Balance + Request)	582656.2565
Administrative - 90%	0.9		\$ -	\$ -		
Federal Evaluation Supports	1		\$ -	\$ -		
Other	1		\$ -	\$ -		
State Evaluation (if approved)	0.5		\$ -	\$ -		
<b>Total</b>		\$ 2,370,700.00	\$ 1,866,747.81	\$ 503,952.19		

<b>CY 2010</b>	<b>Rate</b>	<b>Total Costs</b>	<b>Federal</b>	<b>State</b>	<b>Summary</b>	
Qualified HCBS	0.82025	\$ 2,604,472.00	\$ 2,136,318.16	\$ 468,153.84	Actual Grant Award for CY	
Demonstration HCBS	0.82025	\$ 589,000.00	\$ 483,127.25	\$ 105,872.75	Total Fed Costs	2935183.391
Supplemental	0.6405	\$ 376,886.00	\$ 241,395.48	\$ 135,490.52	Balance	-2935183.391
Administrative - Normal	0.5	\$ 148,685.00	\$ 74,342.50	\$ 74,342.50	Award Request for next year	5238821.78
Administrative - 75%	0.75		\$ -	\$ -	Total (Balance + Request)	2303638.389
Administrative - 90%	0.9		\$ -	\$ -		
Federal Evaluation Supports	1		\$ -	\$ -		
Other	1		\$ -	\$ -		
State Evaluation (if approved)	0.5		\$ -	\$ -		
<b>Total</b>		\$ 3,719,043.00	\$ 2,935,183.39	\$ 783,859.61		

CY 2011	Rate	Total Costs	Federal	State	Summary	
Qualified HCBS	0.82025	\$ 3,640,946.00	\$ 2,986,485.96	\$ 654,460.04	Actual Grant Award for CY	
Demonstration HCBS	0.82025	\$ 899,500.00	\$ 737,814.88	\$ 161,685.13	Total Fed Costs	4123321.146
Supplemental	0.6405	\$ 501,109.00	\$ 320,960.31	\$ 180,148.69	Balance	-4123321.146
Administrative - Normal	0.5	\$ 156,120.00	\$ 78,060.00	\$ 78,060.00	Award Request for next year	0
Administrative - 75%	0.75		\$ -	\$ -	Total (Balance + Request)	-4123321.146
Administrative - 90%	0.9		\$ -	\$ -		
Federal Evaluation Supports	1		\$ -	\$ -		
Other	1		\$ -	\$ -		
State Evaluation (if approved)	0.5		\$ -	\$ -		
<b>Total</b>		\$ 5,197,675.00	\$ 4,123,321.15	\$ 1,074,353.85		

## Attachment O

### List of Acronyms

Acronym	Full description
CMS	Center for Medicaid and Medicare
CAP/Choice	Community Alternatives Program/Choice
CAP/DA	Community Alternatives Program/Disabled Adults
CAP/MR-DD	Community Alternatives Program/Mentally Retarded/Developmentally Disabled